DEPARTMENT OF HEALTH AND SOCIAL SECURITY
WELSH OFFICE
Central Health Services Council

STANDING MATERNITY AND MIDWIFERY ADVISORY COMMITTEE

Domiciliary Midwifery and Maternity Bed Needs

Report of the Sub-Committee

LONDON
HER MAJESTY'S STATIONERY OFFICE
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CHAPTER I

PREFACE

1. At their meeting on 29th June 1967 the Minister of Health's Standing Maternity and Midwifery Advisory Committee considered papers prepared by the Department* on the future of the domiciliary midwifery service and on bed needs for maternity patients. The former paper drew the attention of the Committee to certain aspects of the domiciliary midwifery service in the context of an increasing hospital confinement rate, a shorter length of hospital stay and the falling birth rate; and in a covering Note the Department sought the advice of the Committee on the future of the local health authority domiciliary midwifery service in the changing situation, having particular regard to the supervision of midwives, the employment of domiciliary midwives in hospitals, the practicability of a domiciliary service run by hospitals, and the care of the neonate.

2. The Committee took the view that the question of bed needs for maternity patients was closely related to the other question on which their advice had been sought and that neither could be considered in isolation. Accordingly they decided that a Sub-Committee should be set up to look into both problems.

3. The Sub-Committee had their first meeting, at which Sir John Peel was elected Chairman, on 6th September 1967, when they accepted the following terms of reference:

> "To consider the future of the domiciliary midwifery service and the question of bed needs for maternity patients and to make recommendations."

4. The Joint Secretaries of the Sub-Committee were Dr. Margaret M. Bates and Mr. R. L. Gordon. Meetings were attended by various officers of the Department; by Dr. Elspeth Warwick of the Scottish Home and Health Department, Dr. Mary Jenkins of the Welsh Office, and by Mr. J. S. Tomkinson and Professor J. P. M. Tizard.

5. The Sub-Committee has met 13 times. Written evidence has been received, in response to questionnaires, from Medical Officers of Health, Chairmen of Local Medical Committees, the Central Midwives Board and the Senior Administrative Medical Officers of Regional Hospital Boards, who also collated evidence received from the Secretaries of Boards of Governors within their Regions, and the Department has produced statistical papers at our request. These and other papers received are considered in Chapter VIII. The Sub-Committee wish to thank the British Medical Association for their co-operation in analysing and summarising the evidence received from Chairmen of Local Medical Committees.

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*In this report, 'the Department' refers to the Department of Health and Social Security. Health service duties and functions in Wales passed to the Secretary of State for Wales on 1 April 1969, while the Sub-Committee were still considering evidence.

CHAPTER II

INTRODUCTION

6. The next following chapter reviews in some detail the developments in the maternity services both before and since the Report of the Maternity Services Committee (hereinafter referred to as the Cranbrook Committee) in 1959. The Sub-Committee have, however, been aware that changes necessary, or already evident, in the field of maternity services cannot be isolated from other more general changes in the health services as a whole. Some of these relevant, but more general, trends and developments are briefly considered in the following paragraphs.

7. Within general practice the tendency towards group working is accelerating, and group practices in their turn afford opportunities for specialisation which were denied to the single handed practitioner and difficult to achieve even by doctors working in partnership. Added to this, the last year or two has seen an upsurge in the planning and building of health centres. Both these developments are likely to continue and may be seen as offering to general practitioners an opportunity to reconsider the part they should play in the provision of maternity services; we are aware that experiments in this field have already met with some success.

8. Concurrently with the trend towards group practices there has been steady progress in the development of schemes of attachment of local health authority nursing staff to general practices. Following the issue by the Department of Health and Social Security of Circular 13/69 this progress may well be accelerated. It has, however, been worthy of note that of the three local health authority services, health visiting, home nursing and domiciliary midwifery, the last has lagged far behind the other two in this development, and the possibility that midwifery does not so readily lend itself to this form of organisation cannot be discounted.

9. In the hospital and specialist services plans are going ahead for the provision of district general hospitals which will provide the focal points hitherto lacking, and the concentration of services which this concept implies must have a radical effect upon the diffuse geographical distribution of the present hospital maternity services. Quite apart from those aspects of existing small maternity units with which the Sub-Committee are directly concerned, it is clear that the maternity services of the future will be affected by the rationalisation already under way.

10. Overriding developments within the existing tripartite structure of the health service, the Green Paper issued by the Minister of Health in 1968 has given rise to wide discussion of possible future changes in the administrative structure of the service as a whole. The Sub-Committee have taken the view that the broad administrative structure is outside their terms of reference, and that their concern with the ways in which maternity services are provided need not be

influenced by possible structural changes. They are confident that their recommendations may be seen as compatible with any administrative changes which are likely to take place.

11. The Sub-Committee have also had in mind the possible implications of the Seebohm Report and the Report of the Royal Commission on Local Government in England. As to the former, the direct effect upon the maternity services of the Seebohm Committee's recommendations is thought to be minimal; less directly, a reduction and concentration of the functions of health departments of local health authorities might seem to offer an opportunity to review midwifery provision within the existing framework, but it is unlikely that such a course, in isolation, would contribute usefully to the solution of the main problems. It is not thought that the recommendations of the Royal Commission are inconsistent with the sorts of proposal the Sub-Committee have to offer.

12. Another development which could have a direct bearing upon the way in which domiciliary midwives are at present employed is the Secretary of State's consideration of the implications of the Salmon Committee's recommendations for local authorities following the recommendations by the National Board for Prices and Incomes (a) that the pay of local authority nursing staff should remain linked with that of hospital nursing staff, and (b) that "Salmon" proposals should be implemented as soon as possible. A Working Party is currently considering this question and is expected to report this year.

13. Since the Sub-Committee was set up the Joint Working Party on the Organisation of Medical Work in Hospitals has issued its First Report, in which the grouping of obstetrics and gynaecology within a "Division" is suggested.

14. Since the Sub-Committee began its work, the Abortion Act 1967 has become law. The Act lays down that except in an emergency, an abortion must be carried out in a National Health Service hospital, in an approved Services hospital or in a place for the time being approved by the Secretary of State for the purpose of the Act. The regulations governing notification under the Abortion Act require each abortion to be notified to the Chief Medical Officer under conditions of strict confidentiality. The number of abortions notified in England and Wales during the first year after the Act came into force was 37,736 but it is still too early to assess its effect on hospital bed requirements.

15. Another piece of legislation with implications for the future of the maternity services was the National Health Service (Family Planning) Act 1967. This enables local health authorities in England and Wales to provide a family planning service for all persons needing it, on non-medical as well as medical grounds, either directly or through the agency of a voluntary body. General practitioners in the National Health Service may also give a family planning service comprising advice and examination as part of general medical services, and hospitals may provide a family planning service for patients requiring it on medical grounds only. Recent studies at home and abroad have shown the value of a hospital based family planning service particularly following delivery and after abortions. An increasing number of medical schools provide teaching in control of fertility and family planning techniques, reference to the need for which was made in the Report of the Royal Commission on Medical Education.

16. Finally, amendment of the law affecting the duties of local health authorities with regard to the provision of midwifery services was contained in Section 10 of the Health Services and Public Health Act 1968. The effect of the relevant provisions was to enable local health authorities (a) to arrange for home nurses or health visitors to visit to provide services during the "lying-in period" other than those for which attendance by a midwife is requisite; (b) to make arrangements with hospital authorities for local authority midwives to provide services in hospitals; (c) to make arrangements for their midwives to work in the areas of other local health authorities; and (d) to provide midwifery services other than in the homes of patients.

17. Most of the matters mentioned above are relevant to the more detailed discussion of the problems, and their possible solutions, contained in later chapters of this Report. Their statement here may serve to set a scene within which the maternity services are part of a rapidly changing total service, one of the dominant features of which is the logical move towards closer integration.

CHAPTER III

BACKGROUND INFORMATION AND STATISTICS

18. The history of the practice of midwifery and obstetrics in this country from their early beginnings, and their gradual evolution as skilled professions regulated by responsible bodies and by successive Acts of Parliament is well known, and need not be repeated here. The provision of maternity services has been extended by successive legislation culminating in the National Health Service Act of 1946 which secured for the first time the availability of complete maternity care for all women. Services concerned with antenatal and postnatal care and delivery, in common with other health services, then became shared between general practitioners, hospitals and local health authorities, and a variety of patterns of care developed, according to local circumstances. The resulting tripartite administration has proved a difficult framework for the efficient administration of maternity services.

19. The Committee of Enquiry into the Cost of the National Health Service under the Chairmanship of Mr. C. W. Guillebaud, which presented its Report in November 1955, recommended that the organisation of the maternity services under the National Health Service should be reviewed at an early date. Paragraphs 631 and 632 of the Report of the Guillebaud Committee stated:

> "631. Many of our witnesses have told us that the division of the health services into three branches has had its most serious impact on the maternity and child welfare services. Responsibility for providing these services is now divided between the hospital authorities, local Executive Councils and local health authorities as follows:
>
> (i) The hospital authorities are responsible for the provision of hospital maternity beds and out-patient antenatal and postnatal treatment in teaching and non-teaching hospitals.
>
> (ii) The local health authorities are responsible for the provision of a domiciliary midwifery service and antenatal and postnatal clinics.
>
> (iii) The Executive Councils are responsible for making contracts with general practitioners who undertake to provide maternity medical services. These services involve the provision of prescribed antenatal and postnatal care, with attendance at the confinement if necessary or if the doctor desires to be present.
>
> A general practitioner obstetrician (i.e. a general practitioner who has been admitted to the obstetric list) may provide maternity medical services to any expectant mother; but a doctor not on the obstetric list may provide such services only for a woman on his own list.
>
> (iv) The position is further complicated by the arrangements for providing emergency medical aid for practising midwives. If a doctor is called by

a midwife to an emergency under the medical aid scheme (i.e. to the confinement of a woman for whom he has not undertaken to provide maternity medical services) the doctor's fees are paid by the local health authority and not by the Executive Council.

632. Even within this general division of responsibility, there appear to be wide variations in the way the services are now being provided between one local authority's area and another. In some areas, the antenatal clinics are still manned by medical officers of the local authority, even though many of the expectant mothers attending the clinics may have booked a general practitioner to provide them with maternity medical services. In other areas, the medical services at the clinics are provided by general practitioners employed by the local health authority on a sessional basis. In others, the clinics may have ceased to provide a medical service at all, and are concentrating increasingly on the development of the educational aspects of antenatal care, i.e., mothercraft (and even fathercraft), diet, hygiene, relaxation exercises, etc. Or again, the general practitioners may be providing 'clinic sessions' in their own surgeries, with the local authority midwives in attendance."

20. As a direct result of the recommendation for a review the Cranbrook Committee was set up in 1956 and produced its report in 1959. Paragraphs 10–16 of the Report of the Cranbrook Committee stated:

"10. During our deliberations we have borne in mind these comments of the Guillebaud Committee. Perhaps we should say at this early stage of our Report that the evidence we received did not suggest that the maternity services were in a serious state of confusion; neither would we be inclined to say that the tripartite structure of the health services has of itself proved more detrimental to the efficiency of the maternity services than to that of the other branches of the health service.

11. Were it a question of reconstructing the personal health services as a whole, closely associated as they are with the work of the general practitioners and the hospitals, in the light of experience gained during the ten years since 1948, it is probable that the majority of us would suggest that a unified service, including of course a maternity service under the control of one authority, might be a desirable arrangement. Our deliberations have convinced us, however, that to suggest, at this stage, any drastic re-organisation of the maternity services alone, so as to place them under the sole control of either the hospital authorities, the local health authorities or of some quite new body, would be to create more problems than it would solve.

12. If we accept, as we are satisfied we must, that confinements will continue to take place both in hospitals and at home and that the existing tripartite system of administration must continue for some time to come, the real problem crystallises into one of co-operation and co-ordination between the individuals providing the various maternity services.

13. We believe that what is required at present is the retention of the existing tripartite structure of the maternity services but with a clearer definition of the responsibilities of the respective bodies providing the different parts of the service and the development—which should then become easier to achieve—of co-ordination and co-operation between them.

14. Our terms of reference include an assessment of the content of the maternity services and we have discussed this in some detail in our Report. In particular, in Chapter 4, we have outlined for the benefit of the lay reader, what we think should be the characteristics of a good maternity service of which we consider a very high standard of antenatal care is perhaps the most important.

15. We have come to the conclusion that under present day conditions the practice of obstetrics requires the exercise of special skill beyond the normal competence of the general practitioner and a degree of experience that, with the present high institutional confinement rate, the average family doctor is unlikely to be able to maintain. We have therefore recommended the retention of an obstetric list and more uniform criteria which should be applied for admission to the list or retention on it.

16. Furthermore we have suggested that provision should be made over the country as a whole of a sufficient number of maternity beds to allow of an average of 70 per cent institutional confinements, with the assumption that the normal period of stay in hospital after delivery will be ten days. We explain in our Report why we have come to these conclusions and indicate certain ways in which co-ordination can be developed.".

These expressed the views of the Cranbrook Committee and set the pattern for the development of the maternity services for the next decade. For the past few years, however, there has been growing awareness that a further review of the maternity services was due.

21. Table 1 (page 67) shows that the live birth rate rose from 15 per 1,000 in 1955 to 18·5 per 1,000 in 1964, but has since declined to 16·9 in 1968. In the period 1955–1965 all births increased by nearly 30 per cent. During this period the number of births in National Health Service hospitals rose by almost 50 per cent. The hospital confinement rate rose from 60 per cent reaching the Cranbrook target figure of 70 per cent in 1965, and by 1967 had reached 75 per cent. The total institutional (i.e. other than domiciliary) confinement rate reached 80·8 per cent in 1968. By contrast the number of maternity beds increased by only 15 per cent in the same period, and the increasing hospital confinement rate was achieved mainly by shortening the length of stay.

22. Table 2 (page 67) shows that the average total length of stay in National Health Service hospitals fell over 13 years from 12·1 days to 8·0 days in consultant units, and from 11·1 days to 6·8 days in general practitioner units. Early discharge within 48 hours from hospital was resorted to in some areas to overcome the shortage of maternity beds, and enable all women in the vulnerable categories to be admitted. The Ministry of Health issued guidance on the planning of early discharge schemes in Circular 6/65 and HM(65)32.

23. Table 3 (page 67) demonstrates the main changes in postnatal stay in National Health Service hospitals, distinguishing booked and unbooked cases, for 1958 to 1968. The percentage of women with postnatal stay in hospital of 2 days or less was 4·9 per cent in 1958 compared with 14·4 per cent in 1968.

24. The provision of maternity services throughout the country is not uniform. Although a 78·6 per cent hospital confinement rate and a 80·6 per cent institutional confinement rate was achieved nationally in 1968 there is marked regional

variation. Table 4 (page 68) compares institutional confinement rates in local health authorities grouped into hospital regions for 1967 and 1968 and shows that the number of authorities achieving a rate of 80 per cent or over increased from 86 to 110, while the number with a rate of 60 per cent or below fell from 3 to 1.

25. The rising hospital confinement rate has had the following effects on the midwifery service:

(*a*) National figures show that domiciliary midwives are becoming less concerned with patients in labour and increasingly occupied with the postnatal nursing of patients discharged early from hospital.

(*b*) This reduction in domiciliary deliveries in some areas has made it difficult to secure sufficient clinical experience for pupil midwives conducting cases on the district. (The Central Midwives Board have made some concessions about the required number of cases.)

(*c*) Experimental schemes have been tried in different parts of the country whereby domiciliary midwives have delivered their patients in general practitioner beds and then following an early discharge, have continued their postnatal care at home. This procedure has now been regularized under the provisions of the Health Services and Public Health Act 1968.

(*d*) The process of attachment of local authority nursing staff to general practices is proceeding rapidly. By early 1967, 17 per cent of health visitors were so attached. There has been a steady though smaller development in the attachment of domiciliary midwives to one or more group practices in local health authority areas. In 1964, 2 per cent, and in December 1966, 8 per cent of all domiciliary midwives were attached in this way. Such attachments have shown the value of doctors, midwives, and health visitors working together as a team. This sharing of care has been much appreciated by the mothers.

(*e*) In certain areas with a very high hospital confinement rate, the cost of maintaining an efficient domiciliary service has become uneconomic.

26. Recent developments have tended to increase the general practitioners' participation in hospital and community services:

(*a*) Attachment schemes involving local health authority domiciliary midwives have already been mentioned.

(*b*) There is a trend towards practice from health centre premises, providing a further link with community services.

(*c*) Growing numbers of group practices are evolving in which one or two members of the group specialize in midwifery and provide this service for all the maternity patients of the practice.

(*d*) General practitioners are replacing local health authority medical officers in staffing the maternity and child health clinics. In particular they are providing the ante and postnatal care for their own patients or for the patients of the group practice.

(*e*) There were 23,035 maternity beds, including 4,882 general practitioner maternity beds, allocated in 1968 which was a net increase of 2·1 per cent over the previous year. General practitioner beds make up about 21 per cent of all maternity beds. Since 1955 the number of general practitioner maternity beds has increased by 82·8 per cent compared with 4·3 per cent for consultant beds.

(*f*) New hospitals are being built incorporating general practitioner beds as part of a fully equipped and staffed maternity unit. The building of district general hospitals will continue this policy.

27. In addition to these changes, there have been difficulties in implementing the Cranbrook recommendation to maintain a good domiciliary maternity service. Despite detailed guidance the proper selection of women who are suitable for delivery in their own homes has not been fully achieved. The Perinatal Mortality Survey (Butler and Bonham 1963) gave evidence of poor selection for home delivery. The Survey showed that in 1958 almost one in four women expecting their first babies and booked for home deliveries had to be admitted to hospital late in pregnancy or during labour. The perinatal mortality rate for these infants of mothers booked for home confinement but transferred to consultant units in late pregnancy or during labour was shown to be three times the national survey average.

28, The North West Metropolitan Regional Hospital Board's Obstetric Survey 1962–1964 (Law 1967) studied in detail four of the high risk groups of mothers identified in the Perinatal Mortality Survey (see paragraph 87) and recommended that all cases in the four high risk groups should be delivered in hospital, with the possible exception of certain selected grand multiparae. Successive Reports of the Confidential Enquiries into Maternal Deaths have also commented on the importance of proper booking.

29. Table 5 (page 68) shows the changes in maternal and perinatal mortality and in hospital and institutional confinement rates since 1955.

30. Instead of recommending that the tripartite structure of the maternity service should be modified, the Cranbrook Committee considered that better methods of co-ordination and co-operation were needed. This was thought to be of such importance that a general pattern of co-ordination was suggested which was capable of being adapted to local circumstances:

"*Chapter 11. Co-ordination Arrangements.*

380. Local maternity liaison committees with a professional membership should be formed to ensure that local provisions for maternity care are utilised to the best advantage. (Paragraphs 310 and 311).

381. Local clinical meetings should be encouraged so that all persons in an area responsible for carrying out maternity care can discuss the clinical aspects of maternity cases. (Paragraph 314).

382. The publication of clinical reports by the hospital authorities, should be encouraged and, with the co-operation of the local authorities, extended to cover the domiciliary midwifery service. (Paragraph 315).

383. A standard co-operation card should be provided for use on a national basis. (Paragraph 316).

384. Arrangements for the exchange of information between the various individuals carrying out maternity care need to be strengthened and we have indicated in paragraphs 319 and 324 and in Appendix VIII the arrangements which should be adopted. (Paragraphs 319 to 324)."

These measures have been implemented with varying degrees of success. Existing arrangements for the exchange of information are cumbersome and time-consuming, and in practice it has been found impossible to reach agreement on the use of a standard co-operation card. The value of maternity liaison committees is said to be often hampered by lack of executive function.

31. In a number of the highly developed countries of the world, including those of Western Europe, North America, Russia, and Eastern Europe, hospital confinement for all mothers has become the established practice. The trend in Britain is towards this, but the reason that complete hospital confinement has not been achieved has been partly due to tradition and partly to limited resources within the National Health Service. International comparisons of the maternity bed ratio per 1,000 population and the related birth rates and average duration of stay in hospital (latest available comparable figures) are shown in Table 6 (page 69).

32. Table 7 (page 69) gives information from the Government Actuary's Department based on mid-1968 population data and anticipates a rising birth rate. Future estimates indicate that by 1971 the number of births will almost have reached the 1964 peak and will continue to increase. The possible effects on the birth rate of changing social and economic conditions and of the Family Planning Act 1967 and the Abortion Act 1967 are unpredictable.

33. The advantages and disadvantages of home and hospital confinements were discussed in the Cranbrook Report. The main argument, which hinges on the safety of hospital delivery on the one hand and the emotional security for the patient and her other children in home delivery on the other, is not easily resolved. The compromise of hospital delivery, followed by early discharge home with suitable supporting care, is a method which has been developing over the last few years and appears to be gaining favour with mothers.

34. There is a need to consider the best deployment of skilled staff. There is some difficulty in staffing maternity units with midwives and the distribution of consultants and other medical staff is uneven.

35. Many of the strictures of the Guillebaud Report on the overlapping of maternity services are still relevant. One of the main difficulties from the point of view of the patient's safety is in the transfer of records and communication generally between her different advisers.

36. There are marked regional differences in social conditions, and this is reflected in the perinatal mortality figures in Table 8 (page 70). A further difficulty is posed by the differing needs of rural communities and the long distances involved in travelling to and from centralised hospitals.

CHAPTER IV

MATERNITY SERVICES PROVIDED BY MIDWIVES

37. As mentioned in Chapter III, it is not proposed to repeat the full historical review of the development of midwifery as a skilled profession provided in the Cranbrook Report. This Chapter will concern itself mainly with those aspects of midwifery in relation to which legislative and other changes during the past few years have had significant effects.

38. Appendix B of the Report of the Work of the Central Midwives Board for the year ended March 31st 1968 shows that during the twelve months ended January 31st 1968 20,399 midwives in England and Wales notified their intention to practise. The total number of midwives notifying their intention to practise shown in Table 9 (page 70) fell between 1957 and 1960, then rose until 1967, and again fell in 1968.

39. Between 1959 and 1968 there has been an increase in the number of certified midwives employed in both hospitals and the domiciliary service. The distribution between the two services is shown in Table 10 (page 71). A small number of midwives practise elsewhere, e.g. the Central Midwives Board's Report for the year ended March 31st 1968 showed that 281 worked in nursing homes and 186 were practising independently. It also recorded that local health authorities employed 375 midwives as non-medical supervisors or assistant supervisors of midwives.

40. Between 1959 and 1968 there has been a considerable change in the pattern of provision of midwifery services. The National Health Service hospital confinement rate has risen from 60·7 per cent to 78·6 per cent. The actual number of births taking place in hospitals and at home is shown in Table 11 (page 72) together with the number of patients delivered in hospitals and other institutions, but discharged early and attended by domiciliary midwives.

41. Comparison of Tables 10 and 11 (pages 71 & 72) shows that while in National Health Service hospitals there has been an increase in both deliveries and numbers of midwives, in the domiciliary field the number of midwives, which decreased annually until 1963, has since then decreased only slightly in relation to the number of domiciliary deliveries, which has fallen steadily each year since 1962. Domiciliary midwives have, however, been increasingly concerned with the postnatal care of patients discharged early following delivery in hospital. Actual numbers of whole-time staff in 1968 were 3,406 showing a decrease for the second year in succession. Part-time staff numbered 3,608; on average they worked 40 per cent of the hours of a whole-time midwife, and many of them were also employed part-time on other nursing duties. Table 12 (page 73) shows the distribution of domiciliary midwives employed by various types of local health authority in 1968. Table 13 (page 73) gives a similar indication of the distribution of administrative and supervisory staff.

42. The age distribution of all midwives practising in the years 1965–1968 is shown in Table 14 (page 73), taken from the Central Midwives Board's Report mentioned above. Over the three years there have been slight declines in the under 29 and 50–59 age group percentages, and a rise in the percentage of practising midwives between 30 and 49 years of age. These trends are too slight to be conclusive, but may reflect some fall in recruitment; there is little sign of unusual wastage among established midwives.

43. While the basic function of the midwife has not changed, there has been increasing recognition of her ability to extend her services beyond the provision of attention at the time of actual delivery, and of her technical competence to give total care to mother and child throughout pregnancy, labour and the puerperium. The following definition of a midwife was agreed by the W. H. O. Moscow Conference:

> "A midwife is a person specially instructed and qualified to provide care for women during pregnancy, delivery and the postnatal period, and for the newly-born infant. This care includes preventative measures, health education, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help".

This definition has been approved by the Central Midwives Board.

44. The recognition of the emotional needs of women by their attendants was emphasised in the report of the Standing Maternity and Midwifery Advisory Committee 'Human Relations in Obstetrics, 1961'. The importance of the proper attitudes and approach to confinement and parenthood by the patient and her family was re-affirmed by a study carried out by the Royal College of Midwives, the report of which, 'Preparation for Parenthood', was published in 1966.

45. The midwife has continued to play a significant part in research since so much depends on trained observation and careful record keeping of all the circumstances leading up to and associated with birth.

46. Within the last decade there have been some fundamental changes affecting the organisation of midwives' work. The most important of these have been:

(i) the rise in the hospital confinement rate and the corresponding increase in early discharge, already mentioned above;

(ii) the development of experimental schemes whereby domiciliary midwives deliver their patients in hospital;

(iii) the attachment of domiciliary midwives to group practices, and the corresponding development of the concept of the obstetric team.

47. The first of these changes has had widespread effects, further reference to which will be made when we consider, in a later chapter, evidence received from Medical Officers of Health. Circular 6/65 issued by the Ministry of Health emphasised the importance of planned early discharges. Planning involves an antenatal visit or visits by the domiciliary midwife to the patient's home, and discussion of the preparation necessary for the reception from hospital, soon after delivery, of mother and newly born infant. The midwife advises and where necessary calls on other resources in the health and welfare services to support or

assist the patient and her family. Following the discharge of the mother and baby from hospital the domiciliary midwife visits in the same way as if the confinement had taken place at home, giving the detailed care and advice needed and handing over to the health visitor when her services are no longer required. It is hardly necessary to stress that co-ordination between local authority, general medical and hospital services is essential when patients are discharged from hospital, whether early or late.

48. The idea of a general practitioner maternity unit in which domiciliary midwives could deliver their patients was put forward more than 10 years ago (Sluglett and Walker 1956). The authors were prompted to suggest such a scheme as a compromise between the rival claims of home or hospital as the best place for a potentially normal confinement. They were also influenced by the fact that in Bristol at that time, as in Britain generally, the trend towards hospital delivery was already becoming established. The scheme was an attempt to combine the advantages of both hospital safety and home care. The arrangements which the paper outlined were essentially simple. It was suggested that the unit should consist of a block of labour wards, attached to a maternity hospital, in which patients would be delivered by their general practitioners and domiciliary midwives and would then be returned to their homes within a few hours of delivery. Since the publication of that paper the idea has gained ground and several schemes based on the original suggestions, by which domiciliary midwives deliver their patients in hospital, have developed. There were until 1968, however, legal limitations to the employment of local health authority domiciliary midwives elsewhere than in the patient's own home. Section 10 of the Health Services and Public Health Act 1968 which replaced and extended the provisions of Section 23 of the National Health Service Act 1946 removed most of the legal difficulties (Appendix A). Schemes of integration vary in nature throughout the country. In Cardiff and Salford, for instance, the general practitioner delivery units are arranged entirely for short stay, the patient being discharged home within a few hours of delivery. Others are run on the lines of maternity units where the patient stays for 48 hours, or longer if necessary for social reasons. One 25 bedded general practitioner unit attached to a maternity hospital opened in 1968 with a midwifery staff consisting entirely of domiciliary midwives is administered by the non-medical supervisor of midwives of the city. In addition to their duties in this unit the midwives care for patients confined in their own homes as well as conducting antenatal and postnatal care in the home.

49. Present trends underline the importance of midwife and doctor working closely together, whether in community or hospital, and co-ordinating with other branches of the health and welfare services. In some areas schemes of attachment to or liaison with group medical practices help the integration between general practitioner and domiciliary midwifery services, giving better and more continuous patient care. Such schemes may, however, be difficult to organise and the attachment of domiciliary midwives is much less common at present than that of health visitors or home nurses.

50. In some areas where patients for hospital confinement live a considerable distance from the hospital, or where hospital antenatal clinic facilities are limited, the antenatal care after the initial booking visit and up to approximately 30–34 weeks of pregnancy is undertaken by the general practitioner and the domiciliary midwife.

51. The Midwives Act 1951 requires the Central Midwives Board to make rules regulating, and restricting within due limits, the practice of midwives, and provides that local supervising authorities should be responsible for general supervision of that practice, no matter by whom the midwives are employed. No changes have taken place in the statutory provisions since the Cranbrook Committee described the situation in 1957 in their Report, although we are aware that the Royal College of Midwives and Central Midwives Board have expressed a desire for revision of the regulations governing the supervision of midwives. Circumstances have changed considerably since these regulations were made; they are now out of date and need to be reconsidered. Further reference to supervision will be made later in this report when we come to consider the evidence received by the Sub-Committee.

52. Courses of training for midwifery take place only at institutions approved by the Central Midwives Board. The training of a pupil midwife comprises theoretical, practical and clinical instruction; attendance on, and the nursing care of mothers and their new born infants. Emphasis is placed upon the midwife's role in health education and preparation for motherhood, including her understanding of the emotional needs of women during pregnancy, labour and puerperium.

53. The course of midwifery training comprises two parts each followed by an examination. For nurses on the general or sick children's parts of the State Register, Part I training lasts 6 months; for those having already taken obstetric nurse training, four months; for nurses on the psychiatric and fever parts of the State Register, enrolled nurses, persons on the Register of the Chartered Society of Physiotherapy who have passed the Final Examination for the Orthopaedic Nursing Certificate and holders of the certificate of the British Tuberculosis Association, 12 months; and for others, 18 months. Part II training lasts 6 months, of which at least 3 months must be spent in domiciliary practice where the pupil will learn community care and during the whole course of her training she must conduct a minimum of 30 deliveries.

54. The number of pupil midwives entering first period training schools during the year ended March 31st 1968 showed, according to figures contained in the Central Midwives Board's Report, a decrease of 68 on the previous year's figures, and the number of pupils entering second period training schools decreased by 112. Of the 5,910 pupil midwives entering the first period training schools in 1967/68, 527 (8·9 per cent) were taking the 4 months course, 4,636 (78·4 per cent) the 6 months course, 434 (7·3 per cent) the 12 months course and 313 (5·3 per cent) the 18 months course.

55. A joint statement by the General Nursing Council and Central Midwives Board announced in 1960 that they had agreed in principle to the provision of a period of obstetric nurse training for female student nurses during general training. A course of 12 weeks training in obstetric nursing enables a reduction of two months to be made in subsequent midwifery training. At March 31st 1968, 152 hospitals, 140 of which had training schemes in operation, had been approved jointly by the Central Midwives Board and the General Nursing Council as obstetric nurse training schools. 1,449 student nurses were then undergoing obstetric nurse training and since 1961 11,927 student nurses have completed training, of whom 974 have qualified subsequently as midwives.

56. The Central Midwives Board have a panel of educational supervisors who visit all hospitals seeking approval to provide training and carry out a regular programme of visits to all midwifery training schools. The Board approve residential and part-time courses of instruction for the midwife Teacher's Diploma Examination, and the refresher courses which midwives in practice are required to attend in accordance with Section G of the Midwives Rules.

57. A working party set up by the Central Midwives Board to consider the future development of midwifery training presented their Report to the Board in October 1966. They recommended combining the present first and second parts of midwifery training into an integrated scheme of training lasting a year with a single examination for the S.C.M. certificate.

58. As a result of the Report of the Salmon Committee on Senior Nursing Staff Structure in the hospital service new schemes based on the Committee's findings are being implemented in some areas. The aim of the Salmon recommendations was to improve patient care by making the nursing and midwifery administration more efficient, by improving its status in relation to hospital administration generally, and by making the higher posts in the nursing and midwifery career structure in hospitals more attractive and more satisfying. Under the new proposals it is hoped that nurses and midwives will be better able to plan their careers with the assurance that they will receive the appropriate training for each new post and will thus be encouraged to take an active interest in management and general administration of the nursing and midwifery services as a whole. The Salmon Report recognised the need for all nurses and midwives involved in administration, whether in the ward or in higher posts, to undergo some form of management training, and recommended that immediately after gaining promotion the nurse or midwife should be given appropriate training for her new responsibilities. Similar needs exist in the domiciliary nursing and midwifery services, and reference has already been made to the working party currently undertaking a review of the domiciliary nursing services.

59. The report by a Sub-Committee of the Standing Nursing Advisory Committee, in 1958, on "Relieving Nurses of Non-Nursing Duties in General and Maternity Hospitals" identified a wide range of duties commonly carried out by nurses and midwives which do not require their particular skills. It discussed methods of relieving nurses and midwives of such duties, and suggested that ward housekeeping teams be introduced.

CHAPTER V

MATERNITY MEDICAL SERVICES PROVIDED BY GENERAL PRACTITIONERS

60. An outline of the administration existing in 1959 was given in the Cranbrook Report. Changes which have occurred since then are dealt with in the following paragraphs, which will be concerned also with statistical trends and other developments affecting general practitioner obstetricians.

61. Details of total numbers of general practitioners, and the numbers of principal medical practitioners analysed by list size and regions are shown in Tables 15 and 16 (pages 74 and 75).

62. In 1962 the Minister of Health in agreement with representatives of the profession made changes in the wording of the definition of, and the terms of service for, maternity medical services and in the system of fees. The revised terms of service for the provision of maternity medical services are:

(i) In the case of maternity medical services the expression "all proper and necessary treatment" shall comprise all necessary medical services during pregnancy, confinement and the postnatal period including:

(*a*) attendance at an emergency in connection with the pregnancy if the practitioner is summoned on behalf of the patient;

(*b*) attendance if summoned by the midwife;

(*c*) where the practitioner is not the practitioner in whose list the person is included, the issue if required to the person or her personal representative of certificates of pregnancy, expected confinement and confinement.

(ii) All practitioners providing maternity medical services should have regard to and be guided by modern authoritative medical opinion such as the advice given by the Standing Maternity and Midwifery Advisory Committee in the memorandum on medical care under the maternity medical services.

63. The current remuneration for maternity medical services provided by general practitioners is as follows:

Item		General Practitioner on the Obstetric List £ s. d.	General Practitioner not on the Obstetric List £ s. d.
1	Complete maternity medical services	15 17 6	9 5 0
2	Complete antenatal care	9 5 0	5 8 0
3 (a) and (b)	Miscarriage	5 6 0	3 6 3
4	Other partial antenatal care, subject to an overriding maximum of	6 12 0	3 17 0
	(*a*) antenatal examinations, each	19 0	11 0
	(*b*) obstetric emergencies, each attendance	1 6 6	15 6
5	Confinement	2 13 0	1 11 0
6	Complete postnatal care	3 19 6	2 16 9
7	Partial postnatal care, subject to an overriding maximum of	2 13 0	1 17 9
	(*a*) each attendance	10 6	7 6
	(*b*) full postnatal examination	1 6 6	19 0

64. The proportion of part services in the maternity work done by general practitioners has increased. In 1962 payment was made for complete services in 306,574 cases and part services in a further 338,264 including miscarriages. The comparable figures for 1968 were 280,168 and 449,597. A number of doctors whose names appear on the obstetric list may no longer take any important share of obstetric work. The average of about 17 cases of complete service and about 27 cases of part service may, therefore be misleading. Table 17 (page 76) shows that in 1968 3,161 complete services and 15,892 part services were given by doctors not on the obstetric list.

65. Of the 397,442 part services (excluding miscarriages) given by all general practitioners in 1968 110,964 or less than one-third were for partial antenatal care without confinement and 150,083 or over one-third were for partial antenatal and partial postnatal care. These figures reflect the increasing extent to which hospitals delegate to general practitioners some of the antenatal and postnatal care of patients delivered in hospital.

66. It is of interest also that of the approximately 820,000 women confined in 1968 the general practitioner was concerned in the care of 677,610 or 83 per cent of them.

67. The number of general practitioners on the obstetric list on 1st October 1968 was 16,407, or 77 per cent of all general practitioners.

68. There has been an increase in the number of doctors awarded the Diploma in Obstetrics of the Royal College of Obstetricians and Gynaecologists, which is intended for general practitioners. It is not known with accuracy how many of these doctors go into general practice. The report of the Working Party of the Royal College of General Practitioners on Obstetrics in General Practice (1968) estimated that about 50 per cent of new entrants to general practice will hold the Diploma. This was based on a survey among 349 doctors in 1965 who had taken the Diploma in 1955, and it was assumed that the proportion of diplomates entering general practice had not changed since 1955.

69. A notice from the Ministry of Health to Executive Councils in December 1960 announced the intention of arranging for review by local obstetric committees, at the end of 5 years, of doctors whose names were included in the obstetric list, in order to approve their retention.

70. In 1966 the Minister of Health in agreement with the representatives of the profession reconsidered the conditions required by a doctor applying to the local obstetric committee for inclusion in the list. Certain minor changes were introduced, which were more in the nature of clarification. They did not apply to doctors already included in the list. The conditions are set out in full in Appendix B.

71. The proposed review of general practitioner obstetricians, referred to above, was postponed because of the "Charter Negotiations" which included a major review of the whole framework of the general medical services.

72. Recent reports which have an important bearing on the general practitioner obstetrician are considered later in this report. These were issued by the Royal Commission on Medical Education, a Working Party on Obstetrics of the Royal College of General Practitioners, and the Council of the Royal College of Obstetricians and Gynaecologists.

73. We are aware that in view of these recent developments the question of revising the obstetric list and the criteria for admission to and retention on it are now being considered by the Department of Health and Social Security.

74. The number of domiciliary confinements attended by midwives under National Health Service arrangements in 1968 was 156,880. The doctor was booked in 153,120 or 98 per cent of confinements and was present at the delivery in 33,279 or 22 per cent of such cases. Of the 3,760 or 2·4 per cent of domiciliary confinements where a doctor was not booked a doctor was present at delivery in 574 or 15·2 per cent of such cases. About half (339,187) of all women, delivered in hospital and other institutions who were discharged home before the tenth day were attended by domiciliary midwives. Of the 187,556 registered legitimate births which took place at home in 1967 9,341 were to mothers who had four or more previous children and 13,000 were to women aged 35 years or more.

75. In 1968, 853 deliveries took place in mother and baby homes registered as maternity homes. A doctor was present at some time during labour in 620 instances. Unsupported mothers constitute a relatively small, but high risk group, the majority of whom are delivered in hospital.

76. In 1968, 7,453 sessions were held by general practitioners employed on a sessional basis to provide antenatal and postnatal care for local health authorities. Sessions held on local health authority premises by general practitioners for their own patients are not included in this figure. In 1965, 682 general practitioners used local health authority premises during the year for antenatal and postnatal sessions reserved for patients on their list. The Cranbrook Report recommended that the general practitioner obstetrician should ultimately replace the local authority medical officer in providing maternity care in local authority antenatal clinics, but in 1968, 31,845 antenatal and postnatal sessions were held by medical officers of the local health authority and by medical officers and midwives jointly.

77. The Cranbrook Report recommended that all general practitioner obstetricians should have access to general practitioner beds, and that these should be within or very close to consultant maternity hospitals or general hospitals with maternity departments. It also suggested that a consultant obstetrician should have overall responsibility for supervision of general practitioner beds. These objectives have not been reached on a national scale for various reasons. Accounts of two experimental schemes based on these precepts (Oldershaw and Brudenell 1968 and Rhodes 1968) are given in Appendix C. These illustrate some of the difficulties encountered in the setting up and running of such schemes. They also suggest that these arrangements are of considerable benefit to the patients.

78. There is now considerable interest in and discussion among the profession on the provision of general practitioner beds in hospital and opinion is moving towards a closer association between general practitioner and consultant beds wherever possible. A major difficulty lies in providing ready access to hospital beds for all general practitioner obstetricians who wish to use them. Decisions on clinical responsibility are not easily resolved but are of fundamental importance. Evidence on these topics is examined in detail later.

79. The development of the maternity services has meant that several different patterns of care are possible for patients, depending on individual and local circumstances. Thus a general practitioner's participation may range from confirmation of pregnancy and arranging for hospital booking at the initial visit, to rendering complete maternity services throughout pregnancy, delivery, and the puerperium. Between these two extremes, the practitioner may share his patient's care in varying degrees with local health authority midwives and hospital staff.

80. In the relatively few instances where local health authority midwives are attached to practices, some continuity of care of patients booked for hospital confinement is ensured, whereas a patient attending a hospital for antenatal care may be seen by a succession of professional attendants. Recently, however, the trend has been for hospitals to delegate more of the antenatal and postnatal care of patients to their general practitioners. The disadvantages of divided responsibility are perhaps of greatest importance during the period of antenatal surveillance, when the exchange of information on the patient's condition may be vital.

81. The co-operation record card, introduced in recent years by the Ministry of Health, was devised in an attempt to facilitate the passage of this information between the patient's professional attendants. If the patient carries this card, and if it has been properly written up there should be no mishaps from lack of information. The report of the working party on Obstetrics in General Practice, published by the Council of the Royal College of General Practitioners (1968) considered the card to be of considerable value where several persons or agencies were involved in the care of one patient, but pointed out that it had not been universally adopted. They referred to frequent overlapping and duplication of records, and thought that the general situation with regard to maternity records was chaotic.

82. Co-operation record cards are found useful for the exchange of information between general practitioner and midwife but are not sufficiently used by hospital staff and are rarely returned to the family doctor. Unfortunately it has not been possible to reach agreement nationally on the form of record card. The Council

of the Royal College of Obstetricians and Gynaecologists in its report on Hospital Obstetrics and the General Practitioner (1968) considered that in an integrated maternity service in which general practitioner obstetricians were part of the team, a single record system covering all cases delivered in the hospital, would be essential.

83. The percentage distribution of the different arrangements for antenatal care was studied by the Perinatal Mortality Survey of the National Birthday Trust (Butler and Bonham 1963) with particular reference to mortality ratios. Table 18 (page 77) is taken from the Report. This shows that except for those with no care, those seen solely by a general practitioner (11·1 per cent) had the highest perinatal mortality. Less than half the mothers in the survey began prenatal care before the sixteenth week. Prenatal care began latest in high parity mothers of whom only 29·3 per cent had presented themselves for examination at 16 weeks gestation.

84. The importance of antenatal care to the outcome of pregnancy for both mother and infant is generally acknowledged. Maternal mortality and perinatal mortality rates are, therefore, to some extent a reflection of the quality of that care. In this connection Table 19 (page 77) shows that although the overall maternal mortality rate in England and Wales fell from 0·47 per 1,000 in 1957 to 0·20 per 1,000 in 1967, the actual number of deaths from toxaemia of pregnancy rose in 1967 to the same number as in 1963. This emphasises the need for continuing scrupulous attention to antenatal care. The general practitioner as doctor of first contact with the pregnant woman has an important function to ensure early arrangements for antenatal care whether he elects to provide maternity medical services or not.

85. The importance of the general practitioner's share in postnatal care has received much less attention. The Report of the Royal College of Midwives on Preparation for Parenthood 1966, showed that many of the women interviewed had complained that the postnatal services were not as supportive as the antenatal services. The general practitioner's role in relation to the care of the baby and family planning advice for the mother, in particular, needs to be considered.

86. Guidance on booking policy for domiciliary confinements was given in the Annual Report of the Chief Medical Officer of the Ministry of Health in 1965 following the findings of the Report on Confidential Enquiries into Maternal Deaths 1961–63. This aimed at restricting domiciliary confinement to potentially normal cases.

87. The North West Metropolitan Regional Hospital Board carried out a detailed survey on four high risk groups: breech presentation, multiple pregnancies, elderly primiparae, and grand multiparae, in relation to place of confinement and obstetric management with special reference to perinatal mortality rates (Law 1967). The report recommended that all cases in the four high risk groups should be delivered in hospital, with the possible exception of certain selected grand multiparae.

88. A recent review of domiciliary obstetrics in a group practice (Hudson 1968) assessed the success of selection of women for home confinement, and concluded that all primigravidae should be booked for confinement in specialist units. (Appendix D).

89. The need for refresher courses in obstetrics for general practitioners has long been recognised. These enable the practitioner to keep abreast of developments in the care of mothers and babies. During the 1967/68 academic year there were 1,158 places on courses in Obstetrics and Gynaecology for general practitioners. Included in these were arrangements for 122 general practitioners to take up clinical attachments.

90. In May 1962, following a pilot experiment in the Metropolitan area, it was suggested to Postgraduate Deans that they should approve selected obstetric units for the provision of a programme of work to be carried out by general practitioners in the course of unpaid clinical attachments under refresher course arrangements.

91. We understand that the type of refresher course which seems to be most appreciated by general practitioners is one which combines a maximum of practical experience with some formal teaching, and in which the general practitioner is not treated as "an extra pair of hands". Where clinical attachments are arranged a regular succession of general practitioners ensures that a proper scheme of training can be worked out, and we understand that it is hoped that eventually such schemes will become part of the work of the regional postgraduate medical institutes.

CHAPTER VI

MATERNITY SERVICES PROVIDED BY HOSPITAL AUTHORITIES

92. The general arrangements for providing maternity services in hospitals under the leadership of the consultant obstetrician have not changed since the report of the Cranbrook Committee.

93. The number of consultant obstetricians appointed by Boards of Governors of Teaching Hospitals and Regional Hospital Boards to be in charge of obstetric units has increased steadily since the National Health Service began. Comparative annual figures from 1959 are shown in Table 20 (page 78). The regional distribution of consultant and general practitioner maternity beds according to Regional Hospital Boards, together with the number of obstetric consultants (whole time equivalent) per million population in 1968, is shown in Table 21 (page 78).

94. The volume of work has, however, undoubtedly increased since 1959 because of the higher hospital confinement rate, the increased turnover of patients made possible by earlier discharge, and changes in clinical management of patients including an increase in operative deliveries.

95. The increase in the number of cases of deliveries in hospitals, forceps deliveries and Caesarean sections for 1958–1966, with total estimated numbers and percentages in England and Wales (H.I.P.E. data) is shown in Table 22 (page 79). Table 23 (page 80) reflects other changes in the pattern of hospital maternity service provision which have substantially, over the years, increased the work for which the consultant obstetrician is ultimately responsible. As the leader of the obstetric team, the consultant's responsibilities include the organisation of the emergency flying squads, evidence concerning which was sought from Senior Adminstrative Medical Officers of Regional Hospital Boards and will be considered in a later chapter.

96. The consultant also has important liaison duties within the obstetric team, both inside and outside the hospital, and between the team and other professional colleagues. This usually includes serving on the local maternity liaison committee, local obstetric committee, and other bodies. His liaison with the consultant paediatrician, whose contribution to the care of the baby in stressed later in this report, is of growing importance.

97. In connection with clinical work, many consultants arrange in-service training for colleagues and members of the obstetric team, and in certain hospitals engage in the teaching of undergraduates and postgraduates, and carry out research programmes.

98. The First Report of the Joint Working Party on the Organisation of Medical Work in Hospital devotes a whole chapter to the key role of the

clinician in administration and management, and it is evident that a more clearly defined managerial role is foreseen for the consultant in the hospital service of the future. In the context of that Report obstetrics and gynaecology would together constitute a Hospital Division. Consultants appointed Chairmen of such Divisions would find themselves also concerned with services such as family planning, the importance of which in the practice of modern obstetrics is touched upon in a later chapter.

99. The provision and siting of general practitioner beds in relation to consultant obstetric units and the relationship and division of responsibility between consultants and other hospital staff and the general practitioners are matters to which reference will be made when we consider the evidence which we have received.

100. In general every young doctor planning to make a career in the hospital obstetric service aspires to, but relatively few can hope to achieve, consultant status. The present number (whole-time equivalents) and distribution of hospital medical staff in obstetrics and gynaecology is shown in Table 24 (pages 82 & 83). In 1968 the number of consultants, 555, compared with 537 in 1967. Of the 555 consultants, 484 were male and 71 female. The total number of senior hospital appointments in the specialty (consultants, senior hospital medical officers and medical assistants) was 591 in 1968. It is estimated that 719 will be required in 1977. Actuarial calculations suggest an annual number of vacancies in the consultant grade of about 30.

101. At present the average age of qualification is between 24–25 years. In theory doctors should be ready for consultant posts by the age of 32. Because of the excess of other posts over consultant posts in the specialty, doctors are spending far longer than necessary in the training grades. Of the 34 consultants appointed between 1st October 1967 and 30th September 1968, only one was under the age of 35, 21 were aged 35–39, and 12 were over 40.

102. The number of senior registrars in the specialty on 30th September 1968 was 85, of whom 78 were born in the British Isles (including Republic of Ireland); there were 159 registrars born in the British Isles and 248 who had been born elsewhere. Table 25 (page 84) shows the number of years they had spent in the registrar grade. The registrar grade was originally envisaged as a training grade for hospital specialists to be held for 2 years. It is therefore apparent that the hospital service is training about 200 doctors a year, of whom 80 are British, for senior registrar posts, of which only about 25 fall vacant yearly. Of the 78 British-born senior registrars in post on 30th September 1968, 8 had been in the grade more than 3 years.

103. A total of 309 doctors took up senior house officers posts in the specialty in 1968. They joined 256 doctors who had already passed a year or more in the grade.

104. A histogram is attached (Table 26 (page 85)) showing the relationship between the theoretical output of British doctors from the registrar and senior registrar grades to the demand for consultant posts. From this it would appear that there are too few senior registrar posts. However, because of the large number of highly trained and experienced people occupying academic posts and working as locums there are more recruits for consultants posts than there are

vacancies. In 1968 there were on average 22 applicants for every consultant appointment, and it is clear that a serious imbalance exists which, it would seem, may only be corrected by changes in the numbers recruited into training grades or by increasing the number of consultant posts in the specialty.

105. The Cranbrook Report (1959) recommended hospital provision for a national average of 70 per cent of all confinements, a stay of 10 days after confinement in the normal case and the provision of seven antenatal beds per 1,000 total births. This suggested a ratio, linked to a birth rate of 16·6 per 1,000 of 0·58 beds per 1,000 general population.

106. In 1968 there were 23,035 maternity beds in National Health Service hospitals representing 0·46 beds per 1,000 total population. Of these beds 4,882, or about 21 per cent, many of them in small units of under 10 beds, were staffed by general practitioners. In 1955, general practitioner beds constituted only 13 per cent of the total. Most of the additional hospital maternity beds that have been provided in recent years have been allocated to general practitioner obstetricians. It was estimated from figures obtained in the Hospital In-Patient Enquiry that in 1966 21·8 per cent of all deliveries in National Health Service hospitals took place in general practitioner beds. Departmental statistics show that a very considerable proportion of these beds are contained in very small units and we understand that it is the Department's intention continuously to review their provision and to replace them, where possible and as the opportunity offers, with larger combined consultant and general practitioner units. The average total duration of stay in general practitioner beds was 6·8 days in 1968 compared with 8·0 days in consultant beds. Table 21 (page 78) shows the regional distribution of consultant and general practitioner beds according to Regional Hospital Board areas.

107. Although the Cranbrook target figure of 70 per cent hospital confinement has already been reached and this upward trend is likely to persist, the increase is not uniform. In 1968 there were local authority areas in which the domiciliary confinement rate was as high as 40 per cent. In other areas the hospital confinement rate is so high that the residual domiciliary midwifery service requires disproportionate and uneconomical staffing if full cover is to be provided. Furthermore there are difficulties in precise forecasting of future birth rates which may be affected by social factors, the availability of family planning advice and the number of pregnancies terminated under the Abortion Act.

108. McEwan (1967) considered that the time had come for revision of the Cranbrook-based maternity bed ratio. He analysed recent trends; the number of births had increased by 30·3 per cent between 1955 and 1964 and the number of births in N.H.S. hospitals was 41·8 per cent greater in 1964 than in 1955. To deal with the rise in case load there were only 1,592 (8·1 per cent) more allocated maternity beds in 1964—an increase confined almost entirely to general practitioner beds. The greater turnover had been achieved by shortening the length of stay, which had declined steadily year by year. It was argued that if the reduction in the average duration of stay nationally continued at the same rate as between 1955 and 1965 a length of stay of 5·5 days would be reached in general practitioner maternity units in 1971 and in consultant maternity units in 1973. An average duration of stay of 5·5 days and an average bed occupancy of 80 per cent applied to the 1965 population and total births would require 16,510 maternity

beds and a new planning ratio of 0·35 maternity beds per 1,000 population. If an average duration of stay of 7·6 days were substituted for 5·5 days then the national norm would be 0·48 beds per 1,000 population. McEwan concluded that the true requirement must lie between 0·35 and 0·48 maternity beds per 1,000 population and that with a new ratio of this order the rapid replacement of old functionally poor accommodation should be possible.

109. Marshall (1967) in commenting on McEwan's article stated that no hospital planner would use a norm based on population alone to calculate the number of maternity beds required. He would first try to estimate the number of births likely to take place in the area to be served and decide on the percentage of births for which he wished to make hospital provision. He considered the concept of average length of stay fallacious in maternity bed planning and advocated instead the use of a throughput figure. In the Manchester Region for example, the throughput per lying-in bed has risen from 24–36 patients a year in the past 10 years. McEwan's suggested throughput of 53 patients per year, is higher than any at present obtaining. Table 27 (page 86), from the National and Regional Hospital Service Statistical Profile 1967, shows staffed beds and throughput in relation to the institutional and the hospital confinement rates.

110. Golding (1967) drew attention to the considerable variation in birth rates even between areas within a hospital region; e.g. Islington had a birth rate of 24·0 per 1,000 in 1965 whilst the corresponding rate was 14·8 per 1,000 in Westminster. He pointed out that a new town in the early stages of settlement could have a birth rate considerably above the average. This suggested that because of the difficulty of accurate prediction maternity units should be built so that some of the beds might be used for other specialties, and that isolated maternity units should not be built.

111. The obstetric aspects of the early discharge of maternity patients were reviewed after a scheme had been in operation for 9 years in Bradford, and 5,000 consecutive case records of patients discharged from hospital within 60 hours of delivery were analysed (Craig and Muirhead (1967)). It was concluded that planned early discharge did not result in increased maternal morbidity, nor did it add to maternal risk. The scheme was considered to be an efficient and economical way of providing the safety of hospital delivery for the maximum number of mothers and babies. It was pointed out, however, that consideration should be given to the provision of suitable accommodation for mothers and babies where readmission became necessary. The readmission rate was less than 1·0 per cent.

112. A complementary enquiry (Arthurton and Bamford 1967) into the paediatric aspects of early discharge in Bradford found "There is no evidence that early discharge offers any advantage for the individual baby as compared with staying in hospital for 10 days, and in fact there are additional risks partly attributed to difficulties in neonatal diagnosis". The authors considered it preferable to avoid the need for readmission, and said that in their experience this would have been reduced by 59 per cent if mothers and babies left hospital on the fifth day.

113. The high perinatal mortality rates compared with some other countries and the avoidable factors revealed in the Confidential Enquiries into Maternal Deaths indicate the need for still greater attention to in-patient antenatal care,

and for a sufficient number of antenatal beds for complicated pregnancies to be available.

114. It will be clear from what is said above that it has, for some time, been known that the Cranbrook recommendations for hospital bed provision are no longer relevant to the changing situation. Because of this, while the planning of new hospitals and maternity units has had to continue, no reliable national target figure for bed provision has been available, and to some extent an *ad hoc* estimation has had to be employed. The trend towards a shorter average stay in hospital after delivery is significant and must affect future planning.

CHAPTER VII

THE CARE OF THE BABY BEFORE AND AFTER DELIVERY

115. The concern of the obstetric services has been to reduce the hazards of childbirth, not only for the mother, but also for the child. It is for this reason that we briefly review infant mortality, and consider the care that should be given to the baby, although these subjects are not strictly within our terms of reference.

116. At the end of the last century the infant mortality rate in England and Wales was over 150 per 1,000 live births. The present infant mortality rate is 18·0 per 1,000 live births. The general decline in infant mortality has, however, brought new problems. Infants suffering from mental and physical handicaps who would have died twenty years ago are now surviving in increasing numbers, and a substantial proportion of them have multiple defects.

117. Table 28 (page 86) shows that notwithstanding the overall decline in infant mortality rates the first week continues to be a critical period during which there is a particular need for expert care.

118. Perinatal mortality (i.e. the number of stillbirths and the number of infant deaths in the first week of life per 1,000 total births) in England and Wales has been recorded since 1928, when the rate was 60·8; it rose to its highest value of 63·4 in 1933, before declining with only slight fluctuations to a level of 24·7 in 1968. There are, however, considerable regional variations (Table 8, page 70), important causes of which may be the social background of the mothers and the relationship of this to age, height, parity and general health, and the standard of obstetric care. The commonest causes of first week deaths are birth injury and asphyxia, immaturity and congenital malformations. About 7 per cent of all births are premature according to the international definition. Low birth weight predisposes infants to special hazards such as respiratory and nutritional disorders and impaired mental and physical development.

119. Good nutrition during pregnancy is important. Any deficiency in early pregnancy, for example of folates, may interfere with the formation and development of the foetus, particularly its central nervous system. The need for early prevention and intensive treatment of anaemia during pregnancy is particularly important.

120. The need for detailed surveillance throughout the antenatal period, in the interests of the child, has assumed greater importance. More accurate methods of monitoring foetal growth and development are being perfected, and these promise to be of help in determining how long to allow a toxaemic pregnancy to progress towards term to reduce the degree of prematurity. The development and widespread adoption of these techniques, together with the artificial induction of labour, has important implications for the provision of antenatal beds and delivery suite accommodation, considered in a later chapter.

121. Another important cause of death has been haemolytic disease of the newborn, accounting for a mortality rate of 0·35 per 1,000 live births in 1967. Attempts have been made for many years to prevent or minimise the haemolytic process. The discovery of a practical method of prophylaxis against rhesus iso-immunization which Clarke and his colleagues first reported in 1958 (Clarke et al 1958), and his subsequent work in this field (Clarke 1968) is an important step towards reducing the mortality of this condition; but much is dependent in the first instance upon the routine estimation of rhesus blood groups during antenatal care.

122. The dangers to the newborn infant of birth injury and asphyxia are well known. All those concerned with the management of the newborn infant should be able to recognise when intervention is necessary and what form this should take. If resuscitative measures are to be effective, the clinical appraisal of the infant at birth and a continuing appraisal in those infants in whom respiration is not normally and rapidly established is essential.

123. Although there are certain predictable factors which suggest that the delivery should take place in a specialist unit, nevertheless an asphyxiated infant may well result from a "normal" delivery in a general practitioner unit or in the home where care is being given by the general practitioner or midwife. Tizard and Davis (1967) gave detailed advice on resuscitation in the home and considered that "a doctor should not undertake domiciliary midwifery unless he knew how to resuscitate a baby in terminal apnoea."

124. The reduction in postnatal stay in hospital (Table 2, page 67) together with the fact that the first week is a critical period in infancy have important implications in planning for neonatal care. Various aspects of the present trend towards delivery in hospital, followed by early discharge with further care by the domiciliary midwife, and by the health visitor, have already been mentioned in this report. There has, however, been no controlled study of the effect, both immediate and late, on the baby of shorter and longer stay in hospital to establish with certainty whether this practice offers the best way of achieving a satisfactory service for the child. A few studies have been published assessing the effects of early discharge on the baby: Hellman et al (1962), Pinker and Fraser (1964), McEwan (1964), Arthurton and Bamford (1967). The last showed that there was no statistically significant difference in mortality rate between babies born in hospital, but discharged home before the tenth day, and those born at home during the period under review. Similarly there was little difference between the admission rate to hospital within the first ten days after birth of babies born in hospital and discharged early, and those born at home. Babies discharged before the age of 24 hours required readmission significantly more often than those sent home on the second day.

125. The report of the Sub-Committee of the Standing Medical Advisory Committee on the prevention of prematurity and the care of the premature infant (1961) recommended the setting up of special care baby units in large maternity units for the care of premature infants as well as mature infants requiring special care. The Sub-committee recommended that six special care cots should be provided for every 1,000 live births in the area. In 1966 some 63,000 infants were admitted to special care baby units; the median duration of stay was 12·5 days.

126. Recent advances in knowledge of the physiology and biochemistry of the newborn have increased the range and complexity of monitoring techniques. In view of this it has been suggested that neonatal units for general care should be provided in the maternity departments of district general hospitals, while facilities for more highly specialised care are concentrated at regional centres. In some large hospitals it might be possible to have a combination of both types of unit. More information is needed about the categories of infants and the numbers requiring intensive care. A review of the present arrangements for special care of newborn infants has been undertaken by the Department and the subject is now under consideration by an expert group, under the chairmanship of Sir Wilfrid Sheldon.

127. The medical examination of the newborn infant is regarded as essential. Medical and nursing staff concerned with the care of the neonate require training and experience in routine screening tests for the early detection of defects, including attention to the possible presence of hidden defects. Consultant obstetricians, general practitioner obstetricians and midwives, who very often carry out the first examination of newborn babies have a special opportunity of recognising the presence of conditions which require urgent specialist attention and therefore the primary responsibility for recognising the need and arranging for the transfer of such babies to specialist care without delay.

128. Besides its importance to the individual and his family, the detection of congenital abnormalities has a wider, epidemiological implication. This has been recognised by the institution of a voluntary system of notification of congenital malformations in England and Wales. The main purpose of the scheme is the early detection of any trends resulting from the use of drugs or exposure to any environmental factor such as an epidemic of virus disease during the mother's pregnancy. In order that this may be done effectively, notifications must be received as early as possible and the information given is limited to malformations observable at birth. This has now been in operation for several years, and the data from the notifications is coded and processed by the General Register Office. The number of notifications of each type is printed monthly and is available to Medical Officers of Health and any significant increase in an area is brought to the notice of the Medical Officer of Health in order that he may investigate it.

129. Apart from defects which are obvious at birth there are others which must be sought for or which manifest themselves at a later stage of development. It has now been fairly well established that certain factors in the prenatal, perinatal and postnatal history carry a greater than average risk that the baby will have or will develop abnormalities. Nearly all local health authorities are now keeping registers of children in the group considered specially at risk of handicapping conditions. Most Medical Officers of Health and paediatricians feel that the concept of the child at risk has focussed attention on the potentially handicapped child and should ensure careful identification and surveillance. It is evident, however, that such registers would have greater value if there was more selection on an individual basis for admission to them.

CHAPTER VIII

EVIDENCE

130. In describing the present situation in the various separate branches of the service and in setting out the problems with which the Sub-Committee are concerned, earlier chapters have already given some indication of the changing attitudes both of professional personnel and of the general public. The Sub-Committee have, since they began their work, received in evidence Reports published by several of the bodies concerned professionally with the maternity services. These Reports and other evidence in the form of statistical papers prepared specially for the Sub-Committee will be discussed later in this chapter. First, however, it is proposed to consider the evidence sought directly by the Sub-Committee.

Medical Officers of Health

131. The form of questionnaire addressed to Medical Officers of Health of all local health authorities in England and Wales is attached as Appendix E. Of 174 questionnaires despatched in October 1967, 167 were returned in time for inclusion in the survey. Figures quoted in the following paragraphs relate, unless otherwise indicated, to these 167 authorities who employed, in all, the whole-time equivalent of 4,843 midwives (3,437 whole-time, 3,427 part-time), 94·6 per cent of the total for England and Wales (5,118).

132. Relevant comparative statistics over the past 10 years have already been discussed in Chapter IV, and it is not therefore necessary to restate here the trends which they revealed, and which were confirmed by the replies to the questionnaire. Other statistical material from the replies concerning vacancies and wastage of midwives, deliveries attended by domiciliary midwives, cases discharged from hospital visited by domiciliary midwives, training in domiciliary midwifery and changes in deployment of domiciliary midwives is shown in Tables 29 to 33 (pages 87–90) which are largely self-explanatory, and the following paragraphs are concerned only with those features of the statistical data which appear relevant to the main problems.

133. Table 30A (page 88) shows that 99 per cent of the confinements attended by domiciliary midwives took place in patient's own homes, and reflects the very small extent to which, at the time of the survey, as Tables 30A and 30B show, the skills of domiciliary midwives were being utilised in hospitals. In the country as a whole domiciliary midwives on average attended 27 confinements annually, those employed by 49 authorities averaged less than 20, and 1,321 midwives actually attended 5 or less. Many of these midwives were employed for the rest of their time in antenatal and postnatal care, while others worked also as home nurses or on other non-midwifery duties for which they are qualified. The latter, however, together with other part-time employed midwives totalling some 50 per cent of all domiciliary midwives, almost certainly attended, on average,

fewer confinements annually that their full-time colleagues. While attendance at confinements is only one aspect of midwifery care, it is an important one, and the need to maintain all midwifery skills by practice is supported by the opinions recorded in Table 30E.

134. As was pointed out in Chapter IV, the proportion of midwives' time spent on the postnatal care of women and babies discharged early from hospital has increased considerably over the past 10 years; Tables 31A and 31D (page 89) relate both to these women and to others discharged from hospital, i.e. those following a stay of more than 10 days, most of whom do not require the services of a domiciliary midwife. It is evident from a comparison of the numbers of cases summarised in Table 31A (page 89) with figures available from hospital statistics that domiciliary midwives attended only about half of all women discharged after hospital confinement. Of the discharges covered by the survey for which the duration of stay was known, 97 per cent fell within the ten day period and as many as 15 per cent occurred within 48 hours of delivery. The peak seems to occur in the range 5–7 days, and the majority of discharges, 72 per cent, took place after stays of 7 days or less.

135. Tables 31A to 31D (page 89) bring out quite marked differences in practice in the areas of different kinds of authority, particularly (Table 31C) in the extent to which domiciliary midwives visited women discharged from hospital. The average percentage of hospital-confined women visited varied from 75 per cent in Wales to 17 per cent in London Boroughs. On the other hand Table 31A shows that the percentage of very early discharges, within 48 hours or less after delivery, in the London Boroughs. (33 per cent) was markedly higher than the average (15 per cent) for England and Wales or that for Wales alone (11 per cent). These figures exemplify local variations both in hospital practice and in local authority policy with regard to domiciliary midwifery provision.

136. It is of some interest that as many as 1,198 domiciliary midwives were either solely engaged, or willing to be solely engaged, in the postnatal care of "early discharge" cases. Table 31E (page 89) suggests that willingness to undertake this kind of work exclusively was evinced to much the same degree (by approximately 15 per cent of all midwives) by midwives in all types of authority except those in Wales, where the proportion was as high as 40 per cent. It seems likely that most of the midwives concerned were working part-time in their professions, since this kind of work is particularly suited to married women and others who are unwilling to be at risk of call at any time of the day or night. On the basis of this assumption it would seem that something approaching one third of part-time domiciliary midwives may be willingly available for a form of duty which the full-time midwife might find somewhat unsatisfying.

137. Local health authorities provide the facilities for community experience which pupil midwives must receive during their training. Tables 32A and 32B (page 90) show that most authorities participate in training and that substantial provision is made to receive pupils from other authorities' areas.

138. Tables 33A to 33D (page 90) record the extent and nature of redeployment of domiciliary midwives which local health authorities have found necessary over the past few years. The reasons for redeployment are various, but of the 107 authorities who reported such changes 40 related them solely to the

decreasing domiciliary confinement rate; a further 49 had changed the range of midwifery duties for this and other reasons; and only 18 had made changes for reasons wholly unrelated to the consequences, in terms of "early discharges". of a rising hospital confinement rate.

139. The extent to which the content of the domiciliary midwife's work has changed as a result of the changing pattern of obstetric practice has already been noted. Redeployment within the skills of the profession is, however, only one, if the major, aspect of the changes which have given rise to this Sub-Committee's existence. What is perhaps equally relevant in the present context is the extent to which local health authorities reported more radical changes in the ways in which their midwives were employed.

140. Of the authorities mentioning reasons, other than a higher institutional confinement, for redeployment, 34 referred to extension of home nursing duties for staff employed as home nurse/midwives. Other changes mentioned included assistance in cervical cytology clinics and family planning clinics. These trends, combined with a reported increase in work in antenatal and mothercraft clinics, suggest that the number of individual midwives employed in the local authority service is not related solely to the case load of domiciliary confinements.

141. Medical Officers of Health were invited to express their views on the form of administration of midwifery services. Of those who offered opinions on future organisation 69 were in favour of some form of unification of the hospital and domiciliary services, 43 would welcome closer co-operation between the services as at present administered, 26 saw no need for change and 7, seeing difficulty in considering these services in isolation from the Green Paper proposals, suggested interim measures. These views, in cross section, were not clearly related either to geographical disposition or to types of authority, and it must be concluded that a considerable majority of Medical Officers of Health recognise a need to meet the changing pattern of demand in the country as a whole.

142. Certain points were recurrent in the views expressed, among them:

(*a*) the importance of maintaining midwifery skills;

(*b*) the need for redeployment of midwives to enable them to work in hospitals and general practitioner units in order to

(i) retain their skills;
(ii) relieve hospital staffing problems;
(iii) achieve job satisfaction;
(iv) improve training facilities;
(v) achieve continuity of patient care;

(*c*) the desirability of attachment of midwives to general practice;

(*d*) the need to consider the future role of the supervisor of midwives;

(*e*) the fear that a hospital orientated service might lose sight of community needs; and

(*f*) the inevitability that some form of domiciliary service would have to be retained.

Chairmen of Local Medical Committees

143. While aware that the Royal College of General Practitioners had set up a working party on Obstetrics in General Practice (the Report of which is considered later in this chapter), the Sub-Committee thought it desirable that evidence should be sought directly from general practitioners on certain specific matters. Accordingly, letters were addressed to the Chairmen of Local Medical Committees asking for their ideas on the part which general practitioners might play in possible co-operative pilot schemes in their areas, and their views on a number of particular aspects of the maternity services, both present and future. The Sub-Committee were assisted in this enquiry by the British Medical Association, who undertook the collation and analysis of replies and prepared a report, which is attached as Appendix F (page 107). The section headings of this Report reflect the specific aspects on which views were sought.

144. The response to this enquiry (58 per cent) was less than had been hoped for, and the reasons for the failure of 42 per cent of Chairmen to reply are not known. The Report at Appendix F makes the point that all the views expressed are of doctors either directly involved in, or particularly interested in, the maternity service, and for this reason they are both relevant and valuable, but it seems likely that at least some doctors in the majority of the non-respondent areas must inevitably be involved in the provision of maternity services.

145. It seems probable from paragraphs 4 to 9 of Appendix F that notwithstanding the majority of responding Chairmen recording views in favour, or acknowledging a need for continuance, of domiciliary midwifery, no extremity of view is prevalent. General practitioners are clearly aware that the indications, both medical and social, for home confinement need to be much more stringently assessed than those for a hospital confinement, in which risks are minimised. The wishes of mothers, and the psychological advantages for some women of having their babies in familiar surroundings are considered but it is evident that general practitioners would not allow such considerations to override physical risks. Even among those doctors who favour a continuance of domiciliary midwifery there is a recognition that midwives undertaking this work should also work in hospitals to maintain their professional skills.

146. Paragraphs 10 to 14 of Appendix F present substantial unity of view about the need for general practitioners to play an important part in the provision of hospital maternity services. Some of the difficulties expressed in paragraph 10 of the Appendix have already affected the progress of experimental schemes under which general practitioners have been given honorary contracts to undertake maternity work in hospitals. In particular the principle of continuity of treatment is difficult to achieve unless general practitioners are able to find time to specialise in obstetrics at the expense of other calls upon their services, a situation seldom realised outside group practices organised to permit such freedom to certain of its members. Paragraph 14 of the Appendix adds the important qualification that the general practitioner obstetrician must meet certain standards of efficiency if he is to be accepted within the hospital service. So far as the use of hospital beds by general practitioners is concerned, the desire of a small majority of respondents for completely separate general practitioner units is tempered by an awareness of the need for ready access to a consultant unit when complications manifest themselves.

147. The views expressed on attachment of domiciliary midwives to general practices, in paragraphs 15–20 of the Appendix, have given its compilers occasion to draw attention to administrative problems which would arise if the midwives concerned were, as many doctors thought they might be, hospital based. The attachment of local authority nursing staffs to general practices currently depends for its success upon the concept of a team all of whose members are, throughout their working hours, concerned only with those patients on the practice list. 45 per cent of those responding not only favoured the extended use of domiciliary midwives in hospitals but considered that in a reorganised service all midwives should be hospital based, and that the domiciliary service should be provided on a rota system under which midwives would undertake, in turn, both hospital and domiciliary work. It was also suggested that district work not calling for midwifery skills should be carried out by other workers and the present law, unlike Section 23 of the National Health Service Act 1946 (now repealed and superseded by Section 10 of the Health Services and Public Health Act, 1968) leaves no doubt that local health authorities are empowered to provide the necessary services.

148. Views expressed in paragraphs 21–24 of the Appendix on the means by which a close relationship between the general practitioner obstetrician and the consultant obstetricians should be established, and indeed on the precise nature of the relationships, varied and personalities were thought important. General practitioner obstetricians are evidently highly conscious of limits of responsibility, but in paragraph 24 it is also apparent that they are less enthusiastic about definitions which would set those limits. The suggestion in paragraph 23 of the Appendix that a consultant obstetrician might take over responsibility for difficult cases would imply some revision of the present definitions, under the Maternity Medical Services, of partial and complete antenatal care. There is, however, general agreement that the consultant should see every patient at critical times during pregnancy. With regard to the setting up of obstetric liaison committees on the lines suggested in paragraph 22 of the Appendix, maternity liaison committees already exist, and it is to be assumed that the suggested obstetric committees would in effect act as sub-committees of the main maternity liaison committees, concerning themselves particularly with the common use of hospital maternity facilities by both consultants and general practitioners.

149. Paragraphs 25 to 30 of the Appendix indicate that not all general practitioners see their future role within integrated units, and that there remains considerable support for the existence of separate general practitioner obstetric units, although here again the importance of proper equipment and ready access to consultant cover is unanimously acknowledged. The provision of arrangements to meet local conditions is regarded as important, and the alternatives of either an on-call rota system or notifying the patient's doctor when she is in labour are suggested for the provision of effective medical cover. In paragraph 29 of the Appendix, however, it is envisaged that if a general practitioner could not attend, the hospital would take full responsibility. Paragraph 26 lays stress on the need to see a general practitioner obstetric unit as an integral part of general practice, although it would be staffed (otherwise than medically) by hospital-employed nurses and midwives.

150. An alternative status for the general practitioner obstetrician is discussed in paragraphs 31 to 34 of the Appendix; although there was universal support

for the appointment of general practitioners as clinical assistants, respondents appear generally to have envisaged practical difficulties in introducing such appointments on any scale. The educational value of hospital work for general practitioners is acknowledged, although here again a primary objective is seen as the future staffing of general practitioner maternity units.

151. Of the very high proportion of respondents commenting upon the obstetric list (paragraphs 35 to 39 of the Appendix) only about a quarter saw it as an outdated formality, and it is not entirely clear whether they also acknowledged that incorporation of maternity work within general medical services might mean the end of special payments to doctors for providing such services. Many recognised a need to limit the practice of obstetrics by some means so as to ensure that maternity services are provided only by those general practitioners with special competence, and suggested that retention on the obstetric list should be subject to periodical review to ensure that skills are satisfactorily retained. In paragraph 39 of the Appendix the hope is expressed that obstetric specialisation will ultimately be concentrated within group practices.

152. In paragraphs 40 and 41 of the Appendix, dealing with training and maintenance of skills, respondents had little to add to the views expressed in the Report on Obstetrics in General Practice published by the Royal College of General Practitioners, and it seems appropriate, therefore, to consider this topic later when reviewing the College's Report as a whole.

153. A substantial minority of respondents, presumably themselves working in rural areas, expressed concern about the provision of adequate services in those areas; possible ways of doing so are put forward in paragraphs 42 and 44 of the Appendix.

154. Paragraphs 45 and 46 of the Appendix offer no single new view on the place of the general practitioner obstetrician in a unified maternity service, but repeat in brief the opinions already dealt with above. Some doctors, like some of their Medical Officer of Health counterparts, thought that the future of the maternity services could not be considered in isolation from other possible changes in the health services as a whole.

Senior Administrative Medical Officers

155. The form of questionnaire addressed to Senior Administrative Medical Officers of Regional Hospital Boards in England and Wales is attached as Appendix G (page 116). In a covering letter Senior Administrative Medical Officers were asked to consult with the Secretaries of Boards of Governors in their Regions before formulating their replies. The resulting statistical material is contained in Tables 34 to 44 (pages 91–94). Reference is made to particular Tables in the following paragraphs.

156. Table 34 (page 91) shows that in all regions general practitioner beds are provided predominantly in completely separate general practitioner units. For the country as a whole 80 per cent of such beds are so sited, and of the others, only three quarters are situated in close proximity to consultant wards.

157. The replies to Question 2 in Appendix G did not lend themselves to tabulation, mainly because the totality of "areas" mentioned could not be statistically related, by size, to the country as a whole. In three regions it was indicated that the requests of priority groups were fully met, but in the other regions there were

43 areas in which additional beds and related services would be needed to meet such requests. Other requests (i.e. not on priority grounds) could not be met in 84 areas, spread over most of the regions (two did not find it possible to give answers to this question). Deficiencies in facilities were spread fairly evenly over those named at the heads of columns 4–7 in Question 2.

158. All regions but one reported difficulties in staffing existing maternity units. Various reasons were given, among them:

(*a*) Poor transport facilities and lack of social amenities, particularly in isolated units.

(*b*) Lack of suitable residential accommodation.

(*c*) Old buildings, overcrowded wards and excessive work loads arising from the increase in hospital confinements associated with early discharge.

(*d*) The unpopularity of night duty.

(*e*) The reduction in salary suffered by S.R.N.s undertaking midwifery training.

(*f*) The higher starting pay available to a newly qualified midwife entering the domiciliary service.

(*g*) Higher salaries paid by nursing agencies.

(*h*) Competition with local industry.

(*i*) Limited experience and poor promotion prospects in small units in rural areas.

(*j*) A preference by staff for work in large teaching hospitals or districts attracting London Weighting.

159. Table 35 (page 91) reflects a wide divergence of views in certain regions. Only 256 out of 651 maternity hospitals have specific catchment areas, although it is thought that such areas could be defined for a further 141; in the remaining 254 cases the possibility is not accepted. In five regions complete definition could be achieved while in three others no catchment areas could be specified at all; the rural or urban nature of the regions concerned appears to bear little relationship to the views expressed, and it seems possible that the concept of a catchment area may have been grasped differently by different respondents.

160. The answers received to Question 5 (Appendix G) related to 196 emergency obstetric services (flying squads) of which one, recently formed, had not become operative at the time of reply. While there was general agreement that ideally a squad should consist of a consultant or registrar (usually the latter), an anaesthetist, a midwife and a pupil midwife or medical student, the actual composition of teams varied, as the summary of personnel in Table 36 (page 92) shows. For 134 of these visits squads used ambulances, private cars or taxis being employed for 55 others; information was not given in the remaining 6 cases. Tables 37 and 38 (page 92) give some indication of the average and maximum durations and distances of outward journeys, the majority of which do not exceed 10 miles and take less than 30 minutes. Nevertheless, a number of squads are called upon to undertake occasional journeys in excess of 20 miles or, more significantly, lasting over 45 minutes. Table 39 (page 93) which is based upon such information as could be provided and reflects figures, some of them incomplete, returned in respect of 175 squads, indicates the wide variety of situations

encountered. Nearly one in seven of the calls were received from general practitioner units many of which, as is mentioned in paragraph 156 above, are situated at some distance from consultant departments.

161. That the provision of hospital-based domiciliary midwifery services is at present very limited in extent is evidenced by the replies to Question 6 (Appendix G). Only 12 hospitals* provided such a service, and they employed the whole-time equivalent of 90 midwives for this purpose, a diminutive proportion of domiciliary staff as a whole.

162. Table 40 (page 93) records the replies received to Question 7 (Appendix G) concerning the employment of domiciliary midwives in hospitals; one region was unable to provide answers to items (c), (d) and (e). (Comparison of these figures with similar ones returned by Medical Officers of Health discloses minor discrepancies which, it is thought, have arisen because the latter antedated the former by about a year). The extent of participation by domiciliary midwives in hospital work is, as was stated in paragraph 133 above, very small; and the degree to which they actually relieve pressure on hospital midwives is, as the answers to item (d) suggest, even smaller. Only 31 domiciliary midwives (whole time equivalent) are recorded as necessarily helping to staff hospitals.

163. The extent to which midwives were, at the time of the questionnaire, employed on particular aspects of the total service to the exclusion of others is indicated in Table 41 (page 93). These figures, to be seen in perspective, need to be related to a total hospital midwifery establishment of approximately 11,000 (whole time equivalent). Something of the order of one quarter of all hospital midwives specialised in various ways, and more than half of these did not undertake deliveries. Question 9 (Appendix G) followed up the point of specialisation, and the replies suggest that in nearly all regions there is, at least in some hospitals, a continuing trend in this direction. Most aspects of midwifery work were mentioned as specialties in this context.

164. While specialisation as such could be the result of conscious planning to achieve rational deployment of personnel within large units, changing patterns in the provision of maternity services have themselves brought about changes in work which hospital midwives undertake. Replies to Question 10 (Appendix G) suggest that in all regions the increase in the number of hospital confinements has necessitated such changes, but other factors, not all related to this increase, have also had their effect. Factors mentioned by five or more regions were:

Planned early discharges	12 regions
Early ambulation	8 „
Changes in obstetric practice	8 „
More instruction in mothercraft	6 „
Central sterile supplies depts.	5 „
New equipment	5 „

165. Vacancies for hospital midwives at 31st March 1968 totalled 1,533 (whole time equivalent), about 14 per cent of total establishment. Table 42 (page 94) shows the numbers of hospitals with vacancies of varying degrees of persistence. Vacancies were spread over all regions, but the Manchester hospital region, with

*At the time of the Survey; there have been more recent developments in this direction.

225 vacancies and 44 hospitals where vacancies had persisted for more than 12 months, appeared to suffer exceptional difficulties. The extent of vacancies in a particular region did not always appear wholly consistent with replies to Question 3 (staffing difficulties).

166. Table 43 (page 94) summarises the kinds of reason given by hospital midwives for leaving their employment during 1967; the total number leaving suggests an annual turnover of the order of 23 per cent. The difficulties of retrospection and uncertainty as to the genuineness of reasons given by staff justify caution in acceptance of these figures, but it is of interest that only a very small minority made reference to insufficiency of congenial work. It has also to be borne in mind that some of those leaving for reasons other than retirement may well have taken up employment as midwives elsewhere, in either the hospital or the domiciliary service.

167. The replies to Questions 14 and 15 (Appendix G) about midwifery training schools are summarised in Table 44 (page 94). The table shows that in general available places are taken up, and indeed in several regions acceptances for Part I courses exceed the places said to be available. Both places provided and acceptances for Part II courses are substantially less than those for Part I courses, and it is evident that these courses are not, in most regions, used to the full. Detailed consideration of the implications of these figures, from the point of view of maximal utilisation of resources, may well be academic in view of the Central Midwives Board's current concern with revision of the pattern of training.

168. Two further questions (16 and 17, Appendix G) sought to elicit both the attitudes of hospital authorities to midwifery training (their need for, and willingness to establish, new schools), and the primary reasons for their wish to expand training facilities. Apart from the objective of establishing the new comprehensive courses proposed by the Central Midwives Board, the most common motive to emerge was a desire to improve recruitment and achieve staff stability.

169. Statutory supervision of the practice of midwifery under Section 31 of the Midwives Act 1951 has legal effect within the hospital service although the statutory supervising authorities are local health authorities, who employ medical or non-medical supervisors to carry out day-to-day supervision. In Question 18 (Appendix G) senior administrative medical Officers were invited to comment upon the effect of such supervision on administration. Responses varied, but greater stress was laid upon the incidental benefits of contact with a local health authority midwifery administrator (closer co-operation, co-ordination of hospital and local authority services in early discharge cases, etc.) than upon the purely technical advantages in a statutory context. Of the latter, mention was made of the supervisor's part in ensuring notification of intention to practise and attendance at refresher courses.

170. The replies to Question 10 (see paragraph 164 above) suggest that the growing practice of early discharge (which, in this context means discharge within 48 hours of confinement) has had a significant effect upon the pattern of work of hospital midwives. Question 19 (Appendix G) was concerned with the administrative difficulties which might attend this practice, and the reactions of hospital midwives to it. A majority of respondents mentioned administrative complications but several of these were relatively minor and not necessarily

uniformly experienced throughout individual regions. The most commonly experienced difficulties were (a) extra clerical and administrative work, and (b) difficulties in contacting ambulances and domiciliary midwives, particularly at weekends and bank holidays. Two respondents commented upon the complication of having to deal with several local health authorities, each with different procedures. One region referred to an increased work load in wards and delivery suites. The reported reactions of hospital midwives were mixed; four regions and one Board of Governors mentioning mainly favourable attitudes and only two regions indicating positive antagonism. The remaining respondents conveyed an impression of acceptance of the practice as a necessity, with some reservations. Adverse comments referred to "conveyor belt" methods with increasing tempo and pressure of work, a reduction in job satisfaction, diminution of the midwife/patient relationship and difficulties in establishing breast feeding. On balance however, despite the criticisms of early discharge, it would seem that a majority of hospital midwives accept both its inevitability and the fact that it meets the wishes of many mothers.

171. Replies to Question 20 (Appendix G) about maternity liaison committees, of which there were 204, revealed considerable variations, both nationally and within regions, in the frequency with which they meet, intervals varying from one month to one year. A majority of respondents thought that the committees were effective, but four thought their effectiveness limited or difficult to assess, while one regarded existing administrative liaison between the three branches of the service as so well organised as to render special liaison committees unnecessary. One comment, that the committees lack executive authority, may have hinted at a means by which the existing machinery might be developed as an integral feature of a service moving towards unification, although the conferment of executive functions would require legislative action.

172. Finally, Senior Administrative Medical Officers were invited (Question 21, Appendix G) to offer their views on the future pattern of services and administration, and asked particularly to estimate consequential midwifery requirements and to comment upon appropriate arrangements for the training of midwives. In broad principle the replies revealed a high degree of unanimity, but inevitably the open nature of the invitation brought responses ranging fairly widely in detail and emphasis. The following paragraphs are headed to indicate the main topics upon which comment was offered.

Future pattern of services and administration

173. Eleven respondents were clearly in favour of a unified service under one authority, and of these eight specified that unification should be based on the hospital. There was one mention of unification under an Area Health Board; another, favouring unification under the district general hospital at local level, went on to comment that administration of maternity services must be considered with that of medical services as a whole. The remainder, by their general comments, implied that they were in favour of much closer integration between hospital and district midwifery.

Hospital confinement rate

174. It was unanimously agreed that the upward trend in hospital confinement would continue. The following extract epitomizes the general view: "There seems to be a gradually increasing appreciation in the profession and amongst the general public that confinement in hospital is the safest arrangement,

irrespective of considerations of finance or convenience. This trend is likely to continue until almost all confinements take place in hospital". Where a forecast of the hospital confinement rate likely to be achieved was given, it was of the order of 90–100 per cent.

The future of domiciliary midwifery

175. Arrangements for domiciliary confinements were, in the light of the forecasts mentioned in paragraph 174 above, disregarded completely by about half of the respondents. Four suggested that a hospital based team would undertake the declining number of cases. Future domiciliary midwifery was seen as being concerned almost entirely with early discharged postnatal cases. It was thought that organisation of their care would depend on local circumstances. It was suggested that in built-up areas hospital-based midwives on a roster might continue the postnatal care of patients in their own homes. Alternatively, certain midwives might specialise in ante and postnatal care, and these might be resident either in hospital or in the community (e.g. married midwives working part-time).

The role of the general practitioner

176. Nearly all respondents discussed the specific role of the general practitioner in the maternity service of the future. The majority foresaw his greater participation in the hospital maternity service through the allocation of more beds for general practitioners. Mention was made of the advantages of flexibility in the allocation of maternity beds, and the sharing of labour suites by consultants and general practitioners. While most replies envisaged an obstetric team, consisting of consultants and their staffs, general practitioner obstetricians, and midwives based on a large specialised obstetric unit, several suggested that planned decentralisation to peripheral units would be justified in rural areas. Opinion was divided as to whether responsibility for potentially normal cases should rest with general practitioners or consultants, but the point was made that in any scheme respective clinical responsibilities must be defined. References to the obstetric list included predictions that a continuing reduction in the number of domiciliary confinements would lead to a reduction in the number of general practitioners included therein, and that the advent of group practices would concentrate maternity work among doctors specially interested in the subject. Revision of the system of remuneration for general practitioner obstetricians was advocated.

Deployment of midwives

177. The effective deployment of trained midwives was frequently mentioned as being important for the future of the service. It was thought necessary to look at the midwifery service as a whole, with patient care of a uniformly high standard as the objective. The discrepancies between work loads in the hospital and domiciliary fields in some areas was noted, and a warning was sounded that the concentration of all deliveries in hospital with extension of early discharge schemes might overwhelm hospital midwifery staff. A number of respondents called for the use of ancillary staff to relieve the trained midwife of all non-essential duties.

Training of midwives

178. About half the comments received were in favour of implementing the Central Midwives Board's proposals for a 1-year combined hospital based train-

ing course. Many considered that the future content of the domiciliary part of the training should be modified to embrace wider aspects of community care.

Hospital midwifery staffing needs

179. There was least agreement on the possibility of estimating future staffing needs, and where estimates were made they differed widely. Several respondents considered that uncertainty about future policy and variable factors such as birth rate and length of stay made estimations impossible. One thought that the present rate of recruitment should be adequate to maintain present standards of service if midwives could be released from non-essential duties, thus increasing the skilled content of their work. The majority, however, considered that an increased number of hospital deliveries would necessitate an increase in staffing. The point was also made that the amount of antenatal and postnatal work undertaken by domiciliary midwives at present is difficult to evaluate in terms of the additional hospital employed midwives who would be required to provide a similar service. Several respondents based their staffing calculations on the factor, used for establishment purposes, of 2·5 beds/midwife. One, however, considered this too crude a method by which to arrive at an accurate picture either of the needs of the patient or of the work potential of the midwife, and contended that a Nursing Dependency Study was needed to establish a proper basis for assessing staffing requirements.

Central Midwives Board

180. Representatives of the Board were invited by the Sub-Committee to attend to offer evidence on certain points, and the Board subsequently submitted a Memorandum of Evidence which is attached, preceded by a list of the questions to which the Board addressed themselves, as Appendix H (page 121).

181. While the Board agreed that there should be integration of the present hospital and domiciliary midwifery services they drew particular attention to problems which would arise in areas where substantial use is made of district nurse/midwives undertaking dual functions. They took the view that there will always be a need for domiciliary midwifery and that certain midwives should be predominantly concerned with co-operation with general practitioner obstetricians.

182. With regard to the future of midwifery training the Board saw advantages, rather than difficulties, stemming from closer integration of general practitioner and consultant maternity units.

183. With regard to the maintenance of midwifery skills, if midwives were allowed to conduct confinements solely in a diminishing domiciliary field the Board would rely upon suitable refresher courses.

184. The Board considered that a revision of the statutory provisions for the local supervision of midwives should be undertaken, and that a distinction should be made between statutory supervision and the organisation or superintending of the service.

185. The Memorandum offered no support whatsoever for the idea of training midwives to undertake only part of total maternal care, as distinct from specialisation after complete training.

186. The Board offered, at item 7 of their Memorandum, specific suggestions for interim measures designed to achieve closer co-operation between hospitals and local authorities. Some of these suggested interim measures imply executive functions which might require legislative action.

Statistical Papers

187. The prediction of bed needs, especially those in delivery suites, is extremely difficult even if the hospital confinement rate to be aimed at has been decided. Some attempt can, however, be made to assess bed requirements having regard to those variable factors which can be numerically defined, and the results obtained can form a basis for planning, both short-term and long-term, in any particular region.

188. At our request the Department's Statistics and Research Division have produced papers on "Factors affecting the needs for maternity beds" and "Factors affecting the provision of delivery beds" which are attached as Appendices I and J (pages 123 and 132). Before turning to the implications of Table 5 in Appendix I, it may be appropriate to consider to what extent the several variable factors named in paragraph 1 of that Appendix are amenable to conscious determination.

189. The paper suggests that a trend towards shorter hospital stay must, in view of the consequently increased turnover, make it difficult to increase the percentage occupancy because the intervals between occupation will not be reduced in proportion. If the average length of stay continues to fall, percentage occupancy is thus a factor of secondary significance in determining bed needs.

190. A substantial reduction in the percentage of beds used for antenatal care cannot be anticipated. The implications for the future are to some extent conjectural and it would seem unwise to plan on the basis of a lower percentage than at present obtains.

191. The factor most closely related, inversely, to the attainable percentage of all births in hospital is the postnatal length of stay.

192. Table 3 in Appendix I (page 125) shows that while the percentage of cases staying up to two days after delivery is increasing steadily, the fall in the average length of stay owes more to an equally steady downward shift in the 9–10, 7–8, and 5–6 day groups. With as many as 50 per cent of cases in the first-half of 1968 in the 9–10 day and 7–8 day groups it is evident that a reduction of only one day's stay in these groups would bring the average length of stay down to something like 6 days. The trend is already apparent and a further reduction to an average length of stay of 6 days or less is likely.

193. On the basis of the broad assumptions that occupancy will remain at about 74 per cent and the percentage of beds used for antenatal care will not fall below 27·5 per cent (the figure shown in Table 1 of the Appendix), and that average length of postnatal stay can be reduced to 6 days or less, Table 5 (page 126) shows that with no substantial increase in the total number of beds available (approximately 23,300), if the beds were strategically distributed, a hospital confinement rate of 90 per cent is almost currently within reach; and that a reduction in the average length of stay to 5 days would make a rate of 100 per cent possible by 1971.

194. Distribution of beds is not, however, by any means even. Regional variations in demand and present provision upset calculations based upon averages, and in consequence the prognosis is not uniformly as optimistic as Table 5 suggests. Some 16 per cent of beds are situated in isolated general practitioner units.

195. While no hypothetical example can take account of all the factors encountered in practice, it is of interest to consider the implications of Table 5 for the planning of a unit to serve a population of 200,000 given a bed occupancy of 85 per cent, an average postnatal stay of 5 days and provision of 25 per cent of beds for antenatal care. If no other factors intervened 70 beds in such a unit could accommodate 16 births in hospital per 1000 population. With poor home conditions necessitating an average postnatal stay of 7 days and a 30 per cent provision of antenatal beds, 130 beds could accommodate 20 hospital births per 1000 population. These examples are deliberately chosen as less than probable situations. They demonstrate, however, that a statistical approach can yield significant results. In the real situation it might be expected, that with a birth rate of 17 per 1000 population, with 25 per cent beds used for antenatal care, a six day average postnatal stay, and 75 per cent occupancy of lying-in beds, something of the order of 0·5 beds per 1000 population, would allow 100 per cent hospital confinement; but this kind of calculation cannot be used indiscriminately for regional planning.

196. The Tables in Appendix I do not take account of beds in delivery suites, adequate provision of which may be of crucial importance. Statistical treatment of this problem is bedevilled by several factors and the paper at Appendix J (page 132) takes account specifically only of the average rate of arrival of patients, the average time spent in the suite, and the possible effects upon delivery bed needs of induced labour. Some allowance is, however, made for the effects of false labour, night deliveries etc. by the addition of fairly substantial tolerances. Operating theatre facilities for caesarian section, post-partum sterilization and other obstetric procedures are not included in the calculations. These needs have not been considered in detail by the sub-committee, being seen as outside their terms of reference.

197. The paper calls for little detailed comment, demonstrating as it does, in the same way as the paper at Appendix I, the value of statistical treatment of problems of this kind. The examples given are based upon satisfaction of maximum demand, and examination of the tables will show that it is in fact likely that for a very high proportion of the time provision of fewer beds would suffice. It can be estimated that in a large maternity unit accommodating 4,400 births annually, and where the average total stay in the delivery area is as long as 18 hours, the delivery suite requires 26 beds of the combined type to cope with the peak demand. However, if non-induced patients are transferred after the first stage to another bed, the total provision needed is slightly higher, viz. 30 beds composed of 15 first stage and 7 second stage, with 8 of the combined type for induced cases.

198. The paragraphs above related to evidence sought directly by the Sub-Committee. In the following sections brief reference will be made to the several reports, policy statements and other documents also received in evidence.

Report of Council on Hospital Obstetrics and the General Practitioner (Royal College of Obstetricians and Gynaecologists)

199. In broad terms the Council's findings are that the time is ripe for consideration of physical and clinical integration of specialist and general practitioner units, development of team work and unification of all maternity services.

200. The gradual disappearance of separate general practitioner maternity units is anticipated, and the view is expressed that a general practitioner obstetrician should have had a minimum of six months post-registration experience in a maternity unit approved for training. In view of the need to provide posts in hospitals for post-graduate training of future consultants it is considered that the numbers of general practitioners who will be allowed to work in hospitals may have to be limited, and this opinion is linked with the expectation that with the development of group practices only a minority of participating general practitioners will wish to practise obstetrics. The consultant obstetrician must inevitably carry the overriding responsibility for all patients booked for delivery in hospital irrespective of whether they are allocated to specialist or general practitioner care. The general practitioner obstetrician should, however, have available to him, in providing intranatal care for his patients in hospital, all the facilities of the hospital including ancillary services such as radiology and pathology. The suggestion is made that selected general practitioner obstetricians might be offered the opportunity to work in hospitals on a sesional basis.

201. Emphasis is laid upon the importance of examination and supervision of all babies delivered in hospital, whether by specialists or general practitioners, by the consultant paediatrician and his staff.

202. The Council agrees with the Department's policy, in any new building programme, of providing general practitioner beds as part of a fully equipped and staffed maternity unit. In their view there is little to be said in favour of small isolated general practitioner maternity units, and ideally the association of general practitioner obstetric beds with fully equipped specialist units should be as close as possible, both structurally and functionally. In particular it is desirable to arrange for common delivery suites serving both general practitioner and specialist beds.

203. In the long term, complete integration within the district general hospital maternity unit is seen as the objective. Advantages would be the close contact which general practitioner obstetricians would enjoy with other professional members of the team in a working situation; the creation of training facilities, to which the general practitioner would contribute, for pupil midwives and undergraduates; and the staffing of general practitioner beds by midwives, nurses and para-medical personnel currently involved in the care of maternity patients.

204. Recognising that it must be some time before fully equipped district general hospitals are functioning in all areas, and that until then isolated general practitioner maternity units may continue to exist, the Council offer the following interim recommendations:

1. Each general practitioner obstetric unit should have attached to it at least one consultant obstetrician and one consultant paediatrician; these should have the overall supervisory responsibility for the unit and its patients and pay regular visits.

2. Each general practitioner maternity home should be linked with the nearest or most conveniently situated specialist maternity unit, and the functional linkage should be as close as possible. The parent hospital should not only take over patients transferred on account of abnormality but provide consultant and 'flying squad' cover. The general practitioner unit might also look to the central sterile supply department of the parent hospital for its equipment and instruments.

3. Only women specifically selected, in accordance with the now generally accepted criteria, on grounds of probable obstetric normality should be booked for delivery in the general practitioner home.

4. There should be set up a Booking Committee which might consist of the matron, the consultant obstetrician, the Medical Officer of Health or his deputy, and a representative of the general practitioner obstetricians. This Committee should formulate policy with a view to ensuring as far as possible that only the potentially normal patients are booked for admission.

5. Every patient booked for delivery in the general practitioner home should be seen *at least* once during the antenatal period by the consultant obstetrician attached to the unit. It is desirable for him to hold regular sessions during which he can not only carry out the routine examination of all patients but also give an opinion upon any other patients at the request of the general practitioners.

6. Every general practitioner unit should be equipped with apparatus for the resuscitation of the newborn and all those practising obstetrics in the unit, including senior midwives, should be familiar with the use of the apparatus provided. Each baby born in the home should be examined at least once by the paediatrician. The majority of consultant obstetricians now accept this as routine practice in their own unit and it is not unreasonable to ask general practitioner obstetricians to accept a similar system, the value of which has been proven.

7. A staff committee, consisting of all the general practitioner obstetricians using the home together with all the visiting consultants, should be established and should meet regularly to decide policy. The chairman of the committee should be elected from the members and could be either a general practitioner or a consultant.

8. A standard method of keeping records should be established and an annual medical report prepared and published.

Statement of Policy on the Maternity Service

(The Royal College of Midwives)

205. The Royal College believes that the hospital and domiciliary aspects of the maternity service should be closely integrated, although they do not regard unification under one or other of the three bodies involved in the present tripartite system as a practical possibility. In the College's view, future unification will depend upon the creation of a Maternity Service Committee as the employing authority for all midwives, but in the meantime integration should be sought to the greatest possible extent.

206. The Statement draws particular attention to the importance of the midwife's role. In relation to the care she should give after the birth no specific definition of the "early postnatal period" is offered, but the view is expressed that flexibility as to the day when the midwife hands over to the health visitor is desirable.

207. While the Statement does not express a view on the future pattern of hospital bed provision, the importance of careful selection of cases for consultant care is stressed, and the need for close association of general practitioner beds with consultant obstetric units is recognised.

208. The continuance of an efficient domiciliary service both for those women wishing to be confined at home and for properly planned "early discharge" cases is visualized.

209. Much importance is attached to antenatal teaching in preparation for childbirth and parenthood by professionally qualified staff. The idea is put forward that some midwives might specialise in this kind of work.

210. The Statement expresses strong views on the future of midwifery training, for admission to which a national education standard is advocated. The division of training into two separate periods is thought to be out-dated, but importance is attached to a sound knowledge of community care. It is suggested that the content of the training syllabus should place greater emphasis upon neonatal care, preparation for childbirth and parenthood, and the emotional needs of women during pregnancy, labour and the puerperium.

211. In its concern with staffing the statement is confined to the existing tripartite structure and, in the hospital field, expresses support for the recommendations of the Salmon Committee. In particular that Committee's concern with access to management training is welcomed, and the College recognises that "mixed" management courses attended by nursing and midwifery staff from the present separate branches of the health services would make a substantial contribution to the success of future integration.

212. The College's Statement refers particularly to the importance of the non-medical supervisor in the field of liaison with the hospital service. While there is recognition that integration of services might necessitate revision of the qualifications for this post, the view is expressed that under the present arrangements supervision of the midwifery service must remain separate from any co-ordination of the local authority's nursing and midwifery services under a more senior officer of special managerial ability, the non-medical supervisor remaining directly responsible to the Medical Officer of Health.

Report of a Working Party on Obstetrics in General Practice (Royal College of General Practitioners)

213. In common with other professional bodies concerned with the provision of maternity services the Royal College's Working Party have concluded that a unified administrative structure would be welcomed although, like the Royal College of Midwives, they express doubts as to the realism of considering such a major change for a single section of the medical services. Effective and active maternity liaison committees are seen as of great value in the transition towards a unified service. The Working Party recognise that the proportion of deliveries in hospital will continue to increase, and consider that early discharge schemes

can no longer be regarded as a temporary expedient but should be carefully planned to achieve true co-operation between all interested parties. In commending continued availability of home delivery for mothers who desire it they make important provisos concerning clinical suitability, home conditions and the need to maintain efficiency in residual domiciliary services.

214. The future role of the general practitioner in the maternity service is seen as an important one, not least from the point of view of providing a personal as well as an efficient service to patients. The Working Party consider that as many general practitioner obstetricians as possible, supported by teams including midwives, home nurses, health visitors, etc., for work in the home, should also have access to hospital beds and should co-operate closely with their specialist colleagues. Extended employment of general practitioner obstetricians in the hospital service to undertake normal obstetrics would, it is thought, release consultants and their staff from routine care, and so improve teaching facilities; with regard to the latter it is considered that general practitioner obstetricians should play a part in the teaching of obstetrics.

215. Co-operation is the keynote of this Report, and the Working Party lay stress upon the need for mutual respect and easy communication between general practitioner obstetrician and consultant. A two-way flow of cases is visualised, the general practitioner not only handing over to a consultant when complications become apparent but also resuming the care of patients who no longer need a consultant's attention. This sort of complementary service would be facilitated by the closest possible integration of general practitioner and consultant beds in hospital units, and the point is made that it is desirable for general practitioner units to be near to specialist units so that specialist help is readily available; ideally the two units should, if separate, be under the same roof.

216. Reference is made to the growing numbers of new entrants to general practice who are qualified for admission to the obstetric list. The Report, however, emphasises the need for special vocational training in obstetrics, and recommends the establishment of post-graduate teaching departments in each region. For the future it is thought that admission to the obstetric list should be restricted, eventually, to doctors with special training and continuing experience in obstetrics, and the need to maintain standards, through an adequate amount of obstetric work, is stressed. Here, as in other evidence received, the concentration of experience by specialisation within group practices is foreseen.

217. Brief reference is made above to training of the general practitioner obstetrician, but the Working Party's Report develops the questions of training and qualification at some length, and we have noted above (paragraph 152) that many Chairmen of Local Medical Committees endorsed the views of the Working Party. They recommend that undergraduate training should continue as at present with emphasis on basic principles and that obstetrics should continue to feature in qualifying examinations. To supplement basic training it is thought that the vocational training already mentioned should consist of six months as a house surgeon in a specialist maternity hospital during which the general practitioner should spend some time in studying care and resuscitation of the newborn, feeding problems and management of the premature baby. He should also attend a gynaecological outpatient department weekly. Thereafter training

would be completed by the conduct of general practice deliveries under supervision at home or in general practitioner units in hospital. For those practising general practitioner obstetricians unable to work continuously in close association with a specialist hospital it is suggested that provision should be made for continuing education by way of residential and non-residential courses, for clinical assistantships of an educational rather than service nature, and for short-term exchanges between hospital doctors and general practitioners.

218. The Working Party have concerned themselves also with the special problems of provision of services in differing kinds of area, and conclude that a standard pattern of service for all cannot be achieved. They express concern with the special obstetric problems posed by differential birth rates, new towns, large concentrations and scattered rural populations.

"The Non-Medical Supervisor of Midwives"—paper published by the Association of Supervisors of Midwives

219. This paper reproduces the Midwives (Qualifications of Supervisors) Regulations 1937 (S.R.O. 1937 No. 398), and sets out in detail both the practical implications of the Midwives Act 1951 for non-medical supervisors and the other, non-statutory functions which they may undertake.

220. Section I of the paper is concerned with supervision under the Midwives Act 1951 within the area of the local supervising authority, but refers also to duties under statutes (Notification of Births Act, Population Statistics Act, Births and Deaths Registration Act, and Public Health Act 1936) other than the Midwives Acts which do not stem directly from the statute with which the Section purports to deal.

221. Other Sections deal with Liaison Duties, Duties Regarding Drugs, Training of Pupil Midwives and Other Duties of the Supervisor, all of them in the context of the present structure of the maternity services, since the paper does not concern itself with possible future developments.

222. The present liaison and other duties of non-medical supervisors set out in the paper reflect the supportive role of the non-medical supervisor under the present tripartite arrangements. Non-medical supervisors are almost invariably, in addition to their statutory duties, responsible for superintending the domiciliary midwifery services provided by their employing local health authorities, and the burden of liaison with other branches of the service evidently falls heavily upon them. The listed liaison duties suggest that the non-medical supervisors may increasingly have assumed additional functions to meet the growing need for maintenance of communications between local health authorities, hospitals and general practice which the changing tripartite pattern has evoked, particularly in the matter of planned early discharge.

First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals

223. Although the Working Party were concerned primarily with the hospital situation, their Report discloses an awareness of the pressing need for improved communications between hospitals and other members of the health services. Their conclusion is that medical care is a single entity although it is provided from

a complex of sources including hospital, general practitioner and community services.

224. The Report suggests that obstetrics and gynaecology, inter alia, might be combined to form a specialty group or "division" within the district general hospital complex. Liaison activities of divisions would include organised contacts with general practitioners and Medical Officers of Health.

225. In referring to inefficient use of beds arising from arrangements for emergency admission the Working Party instance the way in which obstetric beds are kept empty for patients who may be admitted in labour. They suggest that the most important requirement is an agreed area plan for maternity work with a recognised booking policy, well understood by hospital and home care services.

Report of the Royal Commission on Medical Education 1965–1968

226. So extensive and wide-ranging a Report cannot properly be epitomised in a few words. The following paragraphs deal selectively with points of particular interest within the context of our own terms of reference.

227. In their consideration of the future pattern of medical care the Royal Commission have concluded that the general practitioner will continue to be the first person to whom the patient will turn for advice. Organisation of general practice will, however, continue to change and a steady trend towards the formation of group practices based on proper premises, good equipment and well trained and organised staff is foreseen, the most obvious and natural setting for which is the health centre. The likelihood that there will be much reliance, within group practices, on functional specialisation by individual doctors accords closely with the views expressed by Chairmen of Local Medical Committees.

228. In common with most observers of the health services as a whole, the Royal Commission note a steady movement towards integration of hospital, general practitioner and local authority services, and they envisage the replacement of present medical categorisation by a broad structure of vocational specialties. Much of the Report is concerned with the changes in medical education which such development will necessitate.

229. With special reference to undergraduate training in obstetrics, gynaecology and paediatrics, it is considered that a period of residence in a maternity unit should be retained to enable students to get a proper appraisal of practical obstetrics. Stress is laid upon the need for thorough grounding in the principles of antenatal and postnatal care; and it is considered that the student should learn something of preparation for childbirth and parenthood, the general principles of human reproduction and the psychological aspects of childbearing. Practical experience of abnormal obstetrics is seen as more properly to be acquired after registration. It is thought also that students should be taught the problems of fertility and infertility and that there should be a family planning clinic and a Department of Paediatrics in every teaching unit. In connection with the latter, there is mention of the need for teaching on the newborn in the maternity unit, including instruction on foetal development and growth, management of the normal and premature infant, infant feeding and the diseases and disorders of the newborn.

230. Recognising the need both to bring into closer relationship training for general practice and other fields and training for hospital specialties, and to remove the dissatisfaction of young doctors about the diffusion of information concerning careers and appropriate preparation, the Royal Commission propose a new pattern of professional training. This would, in brief, comprise four stages: (a) an intern year; (b) general professional training lasting about three years; (c) further professional training; and (d) continuing education and training for all doctors in career posts. The aim would be to extend and reorganise post-graduate medical education so as to provide a systematic and rational progress from basic qualification to the appropriate level of career competence and to maintain that competence thereafter. In the field of general practice the suggestion is put forward that within the three year's general professional training a six-month appointment in obstetrics and gynaecology would be highly desirable.

Report by a Committee of the Scottish Health Services Council—The Staffing of the Midwifery Services in Scotland

231. This Report was published in 1965, and shows that by as early as 1963 the trends in hospital and domiciliary confinement rates which have given rise to this Sub-Committee's existence were already well advanced in Scotland. The Scottish Committee were primarily concerned with midwifery recruitment, training, work and establishments, and with the optimum use of skills, in both the hospital and the domiciliary services. They were assisted in their deliberations by the results of a work-study carried out by the Scottish Home and Health Department.

232. The Scottish Committee were persuaded that although for the time being domiciliary services should remain in the hands of local authorities, in the long run the decline in domiciliary confinements coupled with an increase in the amount of domiciliary postnatal care might lead urban authorities to decide to give up direct employment of midwives and ask the hospital authorities to provide a domiciliary service on their behalf. Other possibilities such as a reduction in midwifery staff and employment of part-time midwives to give postnatal care, or combination of the midwifery with the health visiting and home nursing services, were considered but thought likely to be less satisfactory, and it was suggested that experiments might be tried in suitable areas to find out how best to overcome the various problems involved in hospital provision of all midwifery services.

233. In the rural areas difficulties in such an arrangement were thought likely to be much greater, largely because in these areas midwifery was combined with district nursing and health visiting, services which hospitals could not undertake. This problem is, in fact, particularly acute in Scotland where doubly and triply qualified nursing personnel are extensively employed by local authorities.

234. The Scottish Committee concluded that regardless of the outcome of the suggested experiments positive efforts should be made to secure co-operation between the hospital and domiciliary services. They saw not merely co-operation, but complete integration of maternity services as a desirable, if not immediately attainable, objective.

CHAPTER IX

DISCUSSION

235. We have been aware from the outset that, notwithstanding our terms of reference, the questions of domiciliary midwifery and hospital bed needs cannot be isolated from the maternity services as a whole. In seeking evidence we have not thought ourselves restricted to a narrow field, and the foregoing chapter has ranged sufficiently widely over the services as a whole to enable us to relate domiciliary midwifery and hospital bed needs to other aspects; while maintaining this perspective we have not, however, set out to study the maternity services exhaustively, as the Cranbrook Committee did. It may be convenient, in considering this evidence, to deal with it in the sequence in which the needs of the mother and baby arise. Some overlapping is inevitable in reviewing a service in which at present the division of responsibilities is by no means clear cut, and which offers alternative facilities at several points.

Medical and midwifery maternity services

236. Whatever the future role of the general practitioner in the maternity services may be he is at present, and is likely to remain, the first point of contact of an expectant mother with the National Health Service. It is therefore important that all general practitioners, whether or not they will continue to provide care throughout pregnancy, should be equipped not merely to diagnose pregnancy and some of its more common early complications but also to offer informed advice to the expectant mother on the services available to her. The Royal Commission on Medical Education recommended that all general practitioners should, within their general professional training, hold a six-month appointment in obstetrics and gynaecology. Because a medical practitioner may at any time, be called upon to treat pregnant women a sound basic knowledge is obviously desirable, and we consider that all general practitioners should have some training in obstetrics and gynaecology during their period of professional training. This is particularly important if the period of time available for obstetric and gynaecological teaching in the undergraduate curriculum is further reduced, as seems likely if the recommendations of the Royal Commission concerning the clinical period of training are accepted. However, we doubt whether it is either practicable or necessary for those general practitioners not intending to practise obstetrics to hold a six months resident appointment in an obstetric department.

237. The Royal College of General Practitioners' Working Party, throughout their report, use the term "general practitioner obstetrician" a description implying the possession of special skills. While we think it right that all general practitioners should have some basic training in obstetrics and gynaecology, we do not think that general practitioners should undertake maternity work, except in emergencies, unless they qualify for admission to the obstetric list. Many Chairmen of Local Medical Committees endorsed this view; The Royal College

of General Practitioners' Working Party foresaw a restriction of admission to the obstetric list to doctors with special training and continuing experience, and emphasised the need to maintain standards. Specialisation within group practices emerges from the evidence as the most likely factor to influence the contribution that will be made by general practitioners to the maternity service, and we would expect the development of health centres further to accelerate this. The proportion of maternity medical services provided by general practitioners not on the obstetric list is small (they represented only about 2½ per cent of all claims paid in 1967).

238. At an early stage in pregnancy the expectant mother may at present be receiving advice from her general practitioner, from the domiciliary midwife at home or at a local authority clinic and may also have been referred to a consultant obstetrician who will see her as necessary in a hospital clinic. While each branch of the maternity services has an important part to play, the division of responsibilities under the present tripartite system of administration runs a risk of overlapping and possibly failure of communications to the patient's disadvantage.

239. The Cranbrook Committee took full note of the overlapping of services which existed at the time of their report, and of the need for a greater degree of planned co-ordination. They recommended that Maternity Liaison Committees should be set up, but the evidence of Senior Administrative Medical Officers suggests that their effectiveness varies from region to region. We consider that these Committees, because of their professional membership, should play an even greater part in bringing the various branches of the service closer. The evidence we have received suggests that a stage has now been reached when integration should begin to replace co-ordination.

240. Although the majority of confinements take place in hospital the period of labour itself represents a very small proportion of the total time during which any particular patient has need of maternity services. Before this stage is reached, as has already been indicated, all three branches share in the provision of care, and it may be appropriate at this point to consider the factors currently influencing the ways in which care is given.

241. The evidence from Medical Officers of Health suggests that there is less difficulty in recruiting domiciliary midwives than in redeploying those in post to put them to the best use. These midwives not only provide antenatal care but, in some areas where establishments have been related to exceptionally high hospital confinement rates, may be heavily engaged in postnatal care of cases discharged early from hospital. Thus while domiciliary midwives continue to contribute very substantially to both antenatal and postnatal care, their work lacks the continuity which may well have been one of the more attractive features of their profession in the past.

242. Payments to general practitioners for part maternity services have increased considerably over the last five years or so, although those for complete services have decreased. General practitioners are concerned at some stage in the care of most pregnant women and are sharing more and more in the provision of care with hospitals.

243. It is essential that those concerned with the delivery should have full details of the antenatal history. The Cranbrook Committee thought that the responsibility for ensuring that antenatal care is provided should be placed on the general practitioner obstetrician but in present circumstances the latter, like the domiciliary midwife, is less than ever providing complete personal service, including the conduct of labour. Continuity of care is a question raised several times in evidence, and such a concept is indisputably a good one. We are concerned, however, that it should not be construed narrowly as a continuous personal relationship between the patient and only one midwife or doctor. Modern organisational trends, such as the creation of health centres, the setting up of group practices and the introduction of off-duty rotas are making this interpretation less and less appropriate.

244. In our view continuity of care calls for efficient sharing of information between those providing maternity care. The fewer concerned in any individual patient's care the more efficiently communications can be made. Communications are not facilitated by the present organisational division of the midwifery profession into hospital and domiciliary midwives.

245. We therefore conclude that one of the first steps towards rational provision of maternity care should be the unification of the midwifery service under a single authority. Both the Central Midwives Board and the Royal College of Midwives have approved the principle of unification of the midwifery service, but we are aware that the Royal College of Midwives and the Royal College of General Practitioners have reservations about the type of authority which should administer a unified service. The Central Midwives Board consider that domiciliary midwifery could in areas where integration is possible, be administered by hospital authorities provided that staffing problems could be overcome. The law has since 1948 permitted local health authorities to make arrangements with hospital authorities for the provision of domiciliary midwifery and where practicable we think this should be encouraged as an interim measure. It will be necessary for well-defined catchment areas to be agreed between hospitals and local health authorities. If employed by hospital authorities, present domiciliary midwives would still be free to live where they chose, would retain their interest and participation in domiciliary work, and the nature of their work, either in or out of hospital, could be planned to suit the wishes of the individual midwife as well as the needs of the service. We see the extension of such arrangements, where practical and locally acceptable, as the least traumatic means by which the unification of the midwifery service might be approached.

246. Under such arrangements midwives would take part in antenatal care whether provided in the home, health centres, general practitioners' surgeries, or hospital clinics, and all midwifery records would be consolidated. It is, of course, envisaged that domiciliary service in rural areas would need to be provided by midwives situated, in relation to the pattern of group practices and health centres, to meet local needs. The district nurse/midwife must be encouraged to continue midwifery duties, if, and when, the midwifery service is unified. All domiciliary midwives would, however, benefit by having closer contact with hospital midwifery and by becoming an integral part of the obstetric team.

247. With a unified midwifery service co-operation with general practitioner obstetricians should be easier. We are in favour of greater participation by general practitioners in hospital maternity work, and we wish to see general practitioner/consultant obstetrician teams combining to provide medical care. The facilities of hospital clinics and health centres, staffed by midwives under a single administration, supplemented where necessary by general practitioner/midwife clinics, should provide a fully adequate service; and the reality of team working should in our view provide truer continuity of care than can at present be achieved. Continuity of care is disrupted when local health authority doctors, who are concerned only with the antenatal and postnatal periods, participate in the service; general practitioner obstetricians are much better fitted to undertake this work, and should be encouraged to do so.

248. We consider that the greater safety of hospital confinement for mother and child justifies the objective of providing sufficient hospital facilities for every woman who desires or needs to have a hospital confinement. Even without specific policy direction the institutional confinement rate has risen from 64·6 per cent in 1957 to 80·7 per cent in 1968, and shows every sign of continuing to rise, so that discussion of the advantages and disadvantages of home or hospital confinement is in one sense academic.

249. Only a minority of women choose home confinement but we accept the view of the Royal College of Midwives and Chairmen of Local Medical Committees that wishes for home confinement should be respected provided, of course, that there are no medical or social contra-indications. In this connection early assessment in social cases, and as soon as possible in medical cases, is important and we share the opinion of Chairmen of Local Medical Committees and others who advocate that at the present time every woman should be seen by a consultant obstetrician at least twice during pregnancy.

250. Medical care of women confined at home should, as we have already suggested, be the responsibility of general practitioners with special training and actively engaged in the practice of obstetrics. We have no wish, however, to see perpetuated a distinctively general practitioner-orientated branch of the maternity services. The desirability of general practitioner/consultant obstetrician team working has already been touched upon, and we think that this would encourage the provision of an integrated service to patients. The more direct the contact of the general practitioner obstetrician with his consultant colleagues the more readily he will call upon hospital facilities for his patients for whom home confinements are planned when abnormalities arise.

251. What we have said in paragraphs 245 and 246 above about unification of midwifery services has obvious implications for midwifery care of women confined at home. The need to maintain midwifery skills, particularly the conduct of labour, by practice featured in the evidence of both Medical Officers of Health and Chairmen of Local Medical Committees. The Central Midwives Board considered that the skills of midwives allowed to conduct confinements solely in a diminishing domiciliary field could be maintained by suitable refresher courses. The gaining of additional practice would also be facilitated if midwives undertaking this work could, from time to time, work with their hospital colleagues. The extension of arrangements under which hospital authorities provided a domiciliary service as agents of local health authorities would make

this easier to achieve, and recent changes in the law permit domiciliary midwives to work in hospitals. A majority of Chairmen of Local Medical Committees were in favour of this, and both in their evidence and that of Senior Administrative Medical Officers the suggestion of a hospital/domiciliary midwifery rota was advanced. We are in favour of this, but realize that there are practical difficulties at present. The view of some Senior Administrative Medical Officers that future domiciliary midwifery might be concerned almost entirely with patients discharged early appears to assume a continued separate existence for this branch of the service, and would have less relevance under a unified service. Both they and the Royal College of Midwives have suggested that some midwives might specialise in particular aspects, and the evidence makes it clear that specialisation is already a feature of hospital midwifery. We share the Central Midwives Board's view that any specialist training should follow full basic training.

252. We consider that the trend towards centralisation in district general hospitals may for some time require modification to meet local needs as far as maternity services are concerned. Home confinements in rural areas will continue to present special problems and for the time being midwives serving these areas will need to be situated locally. Unforeseen need for hospitalisation or immediate consultant attention in such cases must be met, and some review of the existing emergency obstetric services may be needed. Chairmen of Local Medical Committees, Senior Administrative Medical Officers and the Royal College of General Practitioners all expressed concern about the problems of rural areas, and we think that the long term solution should be the provision of hostel beds to enable admission of women to hospital before labour commences.

253. There will be a continuing need for general practitioner obstetricians and midwives to work closely together in providing care for women confined at home. Chairmen of Local Medical Committees commended attachment schemes, but the present concept of attachment is not wholly consistent with their view that domiciliary midwives should be employed in hospitals. We must emphasise that full co-operation is best achieved on the lines suggested in paragraphs 243 to 247 above, and that individual attachment of midwives should be replaced by continuity of association of particular groups of midwives with particular practices, based where possible in health centres or group practices.

254. Support for continued provision of separate general practitioner obstetric units came mainly from Chairmen of Local Medical Committees, with the qualification that proper equipment and ready access to consultant cover should be available. Evidence from Senior Administrative Medical Officers, however, showed that a very large proportion of general practitioner beds are in completely separate units too remote from consultant units to satisfy this qualification. We consider that admission to separate general practitioner units must be restricted to normal cases. Both the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists favour integration of general practitioner and consultant beds under one roof. We agree with this, and consider that small isolated general practioner units should be replaced as soon as possible by larger combined consultant and general practitioner units in general hospitals. We recognise that for some time to come the retention of some separate general practitioner units will be necessary to maintain a service; while they continue to exist it is essential that their links with consultant units should

be very much closer than they are at present and there should be officially appointed obstetricians and paediatricians. As with women confined at home, patients in these units should have access to all the facilities which a modern maternity service can provide. We would expect midwives working in the community to help in the staffing of these units, since they will, with the general practitioner obstetricians, have shared in the antenatal care of the patients concerned.

255. We are not convinced that in the isolated general-practitioner maternity unit either the on-call rota system or the system of notification of the general practitioner concerned when his patient is in labour, alternatives suggested by Chairmen of Local Medical Committees, can provide complete medical cover. In combined consultant/general practitioner units we would envisage no insurmountable problems, assuming that a good working relationship between general practitioners and hospital medical staff has been established. Indeed, we hope that either by the appointment of general practitioners as clinical assistants, or by other means, general practitioners would share in the work of the unit in co-operation with consultant obstetricians. In the present isolated general practitioner maternity units it must ultimately be for the hospital authorities to ensure that medical cover and equipment is adequate, and we have little doubt that the financial and other implications of providing satisfactory cover will influence them in decisions as to retention of these units. The future status of general practitioner obstetricians in a hospital-orientated maternity service may depend largely upon the extent to which they demonstrate that they wish to be involved.

256. An increase in midwifery staff was envisaged by Senior Administrative Medical Officers as a consequence of any increase in hospital confinements, but this was in the context of the present divided service. It is to be hoped that a move towards the unification of midwifery might lead to a more rational deployment of midwives. Although unification of midwifery might contribute to the removal of some of the disincentives to the recruitment of midwives which Senior Administrative Medical Officers reported, others may be less easy to deal with.

257. Staffing of small maternity units is extravagent. We therefore regard it as important that some priority should be given to the abolition of small maternity units and the provision of modern facilities, both for patients and staff, in new, well-sited buildings. Both Senior Administrative Medical Officers and Chairmen of Local Medical Committees suggested that ancillary staff should be employed to relieve midwives of work not requiring their skills, and we think that this practice should be extended. The part-time employment of married midwives should be encouraged.

Bed needs

258. We have said sufficient above to indicate our main views on the provision of medical and midwifery cover in hospital. We now turn to particular aspects of the hospital maternity service, including bed needs.

259. The papers which we commissioned have persuaded us that statistical methods are of great value. While in broad terms we consider, for example, that with a birth rate of 17 per 1,000 population, with 25% of beds used for antenatal care, a six day average postnatal stay, and a 75% occupancy of lying-in beds,

something of the order of 0·5 beds per 1,000 population would allow 100% hospital confinement, we do not think that this sort of prediction can be used indiscriminately. We consider that all regional planning of maternity bed provision should, subject to local adaption, be based upon statistical techniques related to relevant factors. The birth rate itself may be difficult to predict until the full effects of family planning provision and abortion become evident.

260. The proportion of maternity beds set aside for antenatal care has shown a slight rise in the last decade. This trend may reflect the growing recognition of the importance of in-patient antenatal treatment, and it would seem prudent not to anticipate any reduction in the percentage of beds required for antenatal care, at present on average about 25% of all maternity beds. Precise future needs for antenatal beds are difficult to predict. The provision of antenatal beds should be related statistically to the births in the area served having regard to the health of the community and its social character.

261. In considering the paper on maternity bed needs (Appendix I) it became evident that the duration of postnatal stay was the factor most likely to influence the number of beds needed to accommodate a given percentage of all births in hospital. If the hospital confinement rate may ultimately reach almost 100%, the possibility of further reduction in the average length of postnatal stay may be of great importance in planning. Averages in this context are determined by the decisions of obstetric teams in particular cases, and it is no part of our brief to encroach upon medical judgement. We observe, however, that the average length of postnatal stay has fallen steadily over several years, and we regard it as important that those planning maternity bed provision should be continually aware of trends of this kind.

262. A majority of Senior Administrative Medical Officers, in their evidence, implied that additional beds would be needed to meet all requests for hospital confinement. Statistical analysis suggests, however, that for the country as a whole the overall number of additional beds needed in the next few years to permit a further substantial rise in the hospital confinement rate may not be great. However, many of them are at present sited in unsuitable accommodation and wrongly distributed.

263. Integration of consultant and general practitioner beds would contribute to greater flexibility in meeting demands, as well as to team working. Flexibility in the use of hospital beds may in fact be a very important prerequisite of economical planning, and in a service like the maternity service for which demand fluctuates seasonally there would be considerable advantage in having access to other beds at times of peak pressure. We therefore suggest that in planning maternity units thought should be given to the possibility of siting them close to other beds the use of which could be varied without detriment to other patients in less immediate need of hospital care.

264. It has already been observed that adequate delivery suite facilities may be of prime importance, and we see no room for economies here. As with lying-in beds, delivery suites should be shared by consultants and general practitioner obstetricians.

265. Not all delivery suites are housed in modern buildings, and the time needed, for example, for cleaning, airing and redecorating may be greater in old

premises. Modification of statistically assessed requirements may be needed in the light of local circumstances.

266. At times of peak pressure, antenatal and lying-in patients may be accommodated temporarily in other hospital beds, but it is essential to provide sufficient delivery suite facilities to meet all contingencies. The increased work at times of great pressure will also have its repercussions on ancillary services, and it is necessary for all departments involved in providing maternity services to have the resources to meet maximum demands.

267. Over and above the need for planning which takes account of periods of peak pressure, contingencies such as temporary or complete closure of a unit because of an outbreak of infection, or for staffing or other reasons, need to be provided for.

Postnatal care

268. Average length of postnatal stay has already been mentioned without considering the extremes, which range from more than 10 days to 48 hours or less. It is to the latter that we shall refer as "early discharges", notwithstanding the definition, closely linked with that of the "lying-in period" for the purposes of the Midwives Rules, employed in connection with local health authority statistical returns. These refer to all discharges before the 10th day as early, a concept which appears to bear little relation to current practice, since as many as 72% of the cases visited by domiciliary midwives during the three months July-September 1967 were reported by Medical Officers of Health to have been discharged after 7 days or less.

269. The evidence of both Medical Officers of Health and Senior Administrative Medical Officers confirmed that early discharges had affected the deployment of midwives. Postnatal care of such cases takes up an increasing proportion of the time of domiciliary midwives, and the pattern of work of hospital midwives has also been changed, not always to their greater satisfaction. The practice, and its further extension, is nevertheless regarded as inevitable, and we do not propose either to endorse or to condemn it; it evidently meets the wishes of many mothers. We think however that, so long as the midwifery service remains divided, more could be done to ensure continuity of care, and that there is a need for much closer, systematic liaison between hospitals and local health authorities, based perhaps on national standard procedures. If hospitals provided a domiciliary midwifery service some of the problems would disappear, but there will be a continuing need for liaison to ensure the provision of supportive services such as home helps and to link appropriately with the health visitor. We consider that whether early discharge is practised or not, definite arrangements should be made for the re-admission of mother and baby to the hospital whenever this becomes necessary for either of them.

270. A particular aspect of postnatal care is the "early postnatal period" to which the Royal College of Midwives referred in their statement of policy, and we agree that there should be no hard and fast rule as to the day when the midwife hands over responsibility to the health visitor. The Royal College of Midwives were concerned to ensure that a midwife attended for at least 10 days, and up to 28 days if necessary. We understand that at present some women discharged from hospital between 6 and 10 days after delivery receive their first

visit from a health visitor if a midwife is not available. In our view there should be flexibility to meet the needs of each mother and baby, and well organised channels of communication between hospital and community services will be necessary to ensure this.

271. Although doctors and midwives have always been concerned with the survival and care of the newborn child, this aspect of the maternity services has not received systematic attention and the Cranbrook Committee did not mention it in their review. Recent developments in ante- and intra-partum care and in resuscitation have shown the possibility of improving the chances of infant survival, and the implications of this for the maternity and paediatric services of the future was one of the reasons underlying the setting up of this Sub-Committee.

272. The immediate postnatal care of every infant, wherever it is born, should include a full clinical examination either by a consultant paediatrician or by a doctor who should be trained and experienced in the detection of deviations from normal development which call for urgent attention or for surveillance.

273. We consider that family planning, which includes spacing as well as limitation, should be an integral part of the maternity service. Obstetricians, general practitioners and midwives should be conversant with modern techniques, and should take the opportunity afforded by antenatal visits to discuss, as early as possible, future family intentions with their patients. The present division of the maternity services and the fragmentation of family planning facilities make it difficult to ensure that patients who are referred to another agency take advantage of the arrangements made for them. The increasing proportion of births taking place in hospital suggests that this could in future be a focal point for the family planning service, linked to the maternity service. Advice, which in selected cases would include the offer of sterilisation, would then be available in the early postnatal period before the patient left hospital. The Sub-Committee consider that family planning is of such importance that it should be provided free as part of any maternity service.

Supervision

274. The part played by the non-medical supervisor of midwives in liaison between hospital and local health authority services was mentioned several times in evidence and it may be appropriate here to consider her future role. We agree with the Royal College of Midwives that a revision of the qualifications for appointment of the non-medical supervisor may be needed and fully accept that there is a distinction between statutory supervision and the managing of the service. Indeed, revision of the Midwives Acts and subsidiary legislation generally as the Central Midwives Board have suggested, may be necessary in the light of the many changes in the practice of midwifery which have occurred since regulation and supervision of the profession first became the subject of enactment.

275. Any reconsideration of the non-medical supervisor's role in a unified service will have to embrace the question of who should employ her and how she should fulfil her respective supervising and managing functions. It is not, however, within our terms of reference to advise which, if any, authority should be responsible for supervision and we therefore merely observe that this question needs careful reconsideration.

CHAPTER X

CONCLUSIONS AND RECOMMENDATIONS

276. The views which we have expressed in the preceding chapter stem largely from evidence related to the divided structure of the National Health Service in which the maternity services operate. We see unification of the maternity services as the ultimate goal.

277. We consider that the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100% hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective.

278. The district general hospital will be the obvious focus for all maternity services, both hospital and domiciliary, in the area served by it. District general hospitals should have close links with health centres.

279. The divisional organisation of obstetrics and gynaecology, with the inclusion of neonatal paediatrics, is welcomed.

280. Medical and midwifery care should be provided by consultants, general practitioners and midwives working as teams.

281. Chairmen of hospital divisions should be responsible, with the community physician, for co-ordination of the hospital and community services needed by mothers and their families.

282. The unification of maternity services implies the employment of all midwives by a single authority directly responsible for the provision of all midwifery services. In such circumstances the present division of the midwifery profession would disappear, and we would welcome this.

283. Small isolated obstetric units should be replaced by larger combined consultant and general practitioner units in general hospitals. In the latter units all beds and facilities should be shared.

284. We recognise that the full implementation of our long-term recommendations might involve substantial additional cost and that it may not be possible to introduce them all quickly in present economic circumstances.

285. Without complete unification of the health service administrative changes can be only of a limited nature. We have therefore suggested changes which should be adopted as interim measures pending full unification. A summary of these recommendations, which should be read in the context of the cited paragraphs, is set out below:

Interim Recommendations

(*a*) *Midwifery Services*

(i) As a first step towards unification local health authorities should

be encouraged to make arrangements with hospital authorities for the provision by the latter of domiciliary midwifery services. Preliminary agreement on well-defined catchment areas will facilitate this. (245, 246).

(ii) Midwifery services for home confinement in rural areas should, for the present, be provided by locally housed midwives until it is possible, by providing hostel beds, to arrange for women in these areas to be admitted, before the onset of labour, for hospital confinement. (252).

(iii) Continuity of patient care is best achieved by continuity of association of particular groups of midwives with particular general practices, based where possible in group practices or health centres. (253).

(iv) Priority should be given to the improvement of facilities in maternity units and working conditions of midwives. (256–257).

(v) The practice of employing ancillary staff to relieve midwives of work not requiring their skills should be extended. (257).

(vi) In relation to the "early postnatal period" there should be no hard and fast rule as to the day when the midwife's responsibility for her patient ends, or as to the day when the health visitor makes her first visit. (270).

(vii) There is a need for revision of the Midwives Acts and subsidiary legislation, particularly that relating to supervision of midwives, in the light of the many changes which have occurred since regulation and supervision of the profession first became the subject of enactment. (274).

(*b*) *Bed needs*

(i) The regional planning of maternity bed provision should, subject to local adaptation, be based upon statistical techniques related to relevant factors. (259).

(ii) The proportion of beds used for antenatal care should not be less than 25% of all maternity beds. (260).

(iii) Those planning maternity bed provision should be continually aware of trends such as the reduction in the average duration of postnatal stay. (261).

(iv) The possibility of siting maternity units close to other beds which could be brought into use for obstetrics at times of pressure should be considered. (263).

(*c*) *The Obstetric Team*

(i) All general practitioners should have some training in obstetrics and gynaecology during their period of professional training. (236).

(ii) General practitioners who do not qualify for admission to the obstetric list should not undertake maternity work. (237).

(iii) General practitioner obstetricians should provide all the antenatal and postnatal care at present given by local health authority doctors. (247).

(iv) At the present time every woman should be seen by a consultant obstetrician at least twice during pregnancy. (249).

(v) Admission to general practitioner units must be restricted to normal cases. (254).

(vi) The links between separate general practitioner units and consultant units need to be improved. (254).

(vii) Either by the appointment of general practitioners as clinical assistants, or by other means, general practitioners should share in the work of combined units below consultant level in co-operation with the consultant obstetrician. (255).

(*d*) *General*

(i) There will be a continuing need for liaison, particularly in early discharged cases, between hospitals and local health authorities to ensure the provision of supportive services such as home helps, and to link appropriately with the health visitor; while midwifery remains divided national standard procedures for early discharge might facilitate continuity of care. (269). Maternity Liaison Committees should play a greater part in bringing the various branches of the service closer. (239).

(ii) Whether early discharge is practised or not, definite arrangements should be made for readmission of mother and baby to hospital where necessary. (269).

(iii) Immediate postnatal care of every infant, wherever it is born, should include a full clinical examination by a doctor trained and experienced in the detection of deviations from normal development. (272).

(iv) Family planning should be an integral part of the maternity service, and it should be provided without charge. (273).

286. The changes in professional thought and the administrative action which, it is recommended in this report, should flow from it, must be associated with a change of community attitudes towards midwifery and maternity matters. To a great extent we look upon this educational responsibility as being one for the professions concerned. The obstetric team, which we have indicated as necessary for the service itself should include amongst its responsibilities the education of the community to the desirability and benefits of the reorganisation. It is expected that in this they will draw on the experience of the community physician and his staff.

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TABLES

TABLE 1

Live birth rates, confinement rates and staffed beds 1955-68

(England and Wales)

Year	Live birth rate	Percentage of total confinements		Beds allocated	
		In all institutions	In NHS hospitals	Consultant staffed	G.P. staffed
1955	15·0	64·3	60·2	16,913	2,670
1964	18·5	70·0	67·1	17,085	4,090
1965	18·1	72·5	69·8	17,341	4,263
1966	17·7	75·0	72·4	17,581	4,428
1967	17·2	78·9	75·4	17,890	4,668
1968	16·9	80·6	78·6	18,153	4,882

TABLE 2

Duration of stay in maternity units 1955-68

(England and Wales)

Year	Average length of stay for all NHS hospitals HIPE		Average total length of stay (antenatal and postnatal beds)	
	Antenatal (days)	Postnatal (days)	Consultant beds (days)	General practitioner beds (days)
1955	4·7	11·0	12·1	11·1
1963	4·2	7·8	9·3	8·4
1964	4·0	7·4	8·8	7·9
1965	4·0	7·2	8·6	7·6
1966	3·9	6·9	8·3	7·3
1967		6·8	8·1	7·0
1968		6·6	8·0	6·8

TABLE 3

Percentage distribution, by days of care after delivery, of confinements in N.H.S. Hospitals in the years 1958 and 1968.

(England and Wales)

Days of care after delivery	Booked		Unbooked		All cases	
	1958	1968	1958	1968	1958	1968 (also cumulative)
0	0·3	0·4	3·0	1·6	0·7	0·5 (0·5)
1	0·7	2·5	9·6	11·1	1·9	3·1 (3·6)
2	1·1	10·0	10·5	23·9	2·3	10·8 (14·4)
3	0·9	7·6	7·4	14·5	1·8	8·0 (22·4)
4	0·8	4·5	4·5	6·5	1·3	4·7 (27·1)
5	1·1	5·9	4·1	5·7	1·5	5·9 (33·0)
6	2·2	9·0	4·2	6·0	2·4	8·8 (41·8)
7	4·4	14·0	4·8	6·1	4·5	13·5 (55·3)
8—10	56·2	37·6	27·6	17·2	52·4	36·3 (91·6)
11+	32·2	8·4	24·5	7·4	31·1	8·3 (99·9)

TABLE 4

Institutional confinement rates, 1967 and 1968

Region	Number of local health authority areas	80% and over		70%—under 80%		60%—under 70%		Under 60%	
		1967	1968	1967	1968	1967	1968	1967	1968
Newcastle	13	7	9	2	3	3	1	1	—
Leeds	10	4	6	4	3	2	1	—	—
Sheffield	16	5	7	8	7	3	2	—	—
East Anglia	8	—	—	2	3	4	4	2	1
Metropolitan regions	46	28	33	14	11	4	2	—	—
Oxford	8	5	7	3	1	—	—	—	—
South Western	10	6	9	4	1	—	—	—	—
Wales	17	17	17	—	—	—	—	—	—
Birmingham	16	2	5	11	11	3	—	—	—
Manchester	16	5	8	8	7	3	1	—	—
Liverpool	8	5	6	2	2	1	—	—	—
Wessex	6	2	3	2	2	2	1	—	—
	174	86	110	60	51	25	12	3	1

TABLE 5

Births, maternal mortality, perinatal mortality and institutional confinements 1955-1968 (England and Wales)

Year	Live birth rate	No. of live births	No. of stillbirths	Maternal mortality rate including abortions per 1,000 total births	Perinatal mortality rate per 1,000 total births	Percentage of confinements	
						In all institutions	In N.H.S. hospitals
1955	15·0	667,811	15,829	0·59	37·4	64·3	60·2
1956	15·7	700,335	16,405	0·52	36·7	64·3	60·4
1957	16·1	723,381	16,615	0·45	36·2	64·3	60·6
1958	16·4	740,715	16,288	0·43	35·0	64·1	60·4
1959	16·5	748,501	15,901	0·38	34·1	64·2	60·7
1960	17·2	785,005	15,819	0·39	32·8	64·7	61·3
1961	17·6	811,281	15,727	0·33	32·2	65·6	62·3
1962	18·0	838,736	15,464	0·35	30·8	65·9	62·8
1963	18·2	854,055	14,989	0·28	29·3	68·2	65·1
1964	18·5	875,972	14,546	0·26	28·2	70·1	67·1
1965	18·1	862,725	13,841	0·25	26·9	72·5	69·8
1966	17·7	849,823	13,243	0·26	26·3	75·0	72·4
1967	17·2	832,164	12,528	0·20	25·4	78·9	75·4
1968	16·9	819,272	11,848	0·24*	24·7	80·6	78·6

*Provisional

TABLE 6

International Comparisons

		Maternity Bed Ratio per 1,000 population	Hospital Confinement Rate per cent	Birth Rate per 1,000	Average length of Total Stay
U.S.S.R.	1964	1·1	99·9	19·6	8–9 days
Czechoslovakia	1966	0·54	98·7	15·6	5–7 days
Sweden	1964	0·50	99·7	16·0	6–7 days
Denmark*	1964	0·14	44·0	17·6	9–9·5 days
Holland*	1962	0·10	29·0	20·9	10–12 days
Yugoslavia	1963	0·21	—	21·4	6 days
England and Wales	1966	0·45	72·2	17·7	8·3 days Consultant Units 7·3 days G.P. Units
England and Wales (Cranbrook recommendations)		0·58	70·0	16·6	10 days Normal stay postnatal

*Does not include private institutions.

It is not possible to calculate maternity bed ratios for the U.S.A.

TABLE 7

Mid 1968 projection (with allowance for migration), showing estimates of live births and birth rates.

(England and Wales)

Year	Live births	Birth rate per 1,000 population
1969	838,000	17·1
1970	854,000	17·3
1971	867,000	17·5
1981	920,000	17·5
1991	1,029,000	18·3
2001	1,096,000	18·0

Note: Provisional birth figures for 1969 indicate that the projection for this year is an overestimate. (The projections used were the most recent available at the time of preparation.)

TABLE 8

Perinatal mortality rate per 1,000 total births by hospital region 1964-1968

Hospital Region	1964	1965	1967	1968
Newcastle	32	30	28·0	24·9
Leeds	30	29	27·1	26·1
Sheffield	29	27	26·1	25·4
East Anglia	25	23	22·0	21·4
North West Metropolitan	24	24	22·6	24·2
North East Metropolitan	26	25	23·7	23·8
South East Metropolitan	27	25	22·5	22·9
South West Metropolitan	26	24	23·7	22·7
Wessex	26	23	23·8	22·8
Oxford	26	22	21·8	20·6
South Western	26	25	22·0	22·3
Welsh	32	30	27·9	27·6
Birmingham	29	29	27·1	25·1
Manchester	32	31	28·3	28·6
Liverpool	31	30	29·9	27·7

TABLE 9

Midwives Roll 1957-1968

(extract from Appendix B of C.M.B. Report 1967/1968)

Year Ended March 31st 1.	No. on Roll 2.	Midwives notifying their intention to practise 3.
1957	61,692	17,006
1958	64,722	16,706
1959	67,768	16,445
1960	71,213	16,582
1961	74,976	17,370
1962	78,725	17,950
1963	82,721	18,378
1964	61,136*	18,724
1965	65,272	19,465
1966	69,425	19,913
1967	73,639	20,011
1968	77,791	20,399

*Clearance of Roll undertaken (C.M.B. Report 1967/8).

Note: The figure in column 3 is for the 12 months ended 31st January of the year of the report.

TABLE 10

Staff (whole-time equivalent) employed at 30th September 1959-1968

(England and Wales)

Year	Midwives in hospital service*	Domiciliary midwives†
1959	‡ 6,942	4,820
1960	‡ 7,221	4,896
1961	‡ 7,605	5,018
1962	7,241	5,185 §
1963	7,790	5,303
1964	8,101	5,298
1965	8,601	5,298
1966	8,810	5,203
1967	9,268	5,118
1968	9,573	4,861

*This figure includes some midwives who are employed by the hospital for work on the district.

†Administrative staff are not included in these figures.

‡Total number of whole-time and part-time. W.T.E. not available for these years.

§As at 31st December.

TABLE 11

Division of work between the hospital and domiciliary services 1959-1968

(England and Wales)

	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968
No. of births in										
(a) N.H.S. hospitals	464,293	490,622	515,274	536,495	566,068	597,438	612,127	624,967	637,078	653,107
(b) Other hospitals*	26,384	27,186	27,168	26,653	26,644	26,163	23,773	22,277	20,058	17,114
(c) At home†	273,725	283,016	284,566	291,052	276,332	266,917	240,666	215,822	187,556	160,899
Domiciliary Midwives										
Deliveries attended	267,940	276,974	278,973	286,357	270,831	261,907	236,782	212,192	184,227	156,880
No. of cases delivered in hospital and other institutions but discharged and attended by domiciliary midwives before the 10th day	148,494	149,044	128,898	149,777	178,698	227,480	263,061	292,628	313,724	339,187

*Non-N.H.S., many of which are maternity homes.

†Includes births occuring in homes for unmarried mothers, remand homes, reception centres, etc.

TABLE 12

Number of authorities and number of domiciliary midwives employed at 30th September 1968.

(England and Wales)

	Number of Authorities 1.	Domiciliary Midwives				Total Number of staff 6.
		Whole-time 2.	Part-time 3.	Whole-time equivalent of		
				Part-time 4.	All staff 5.	
All authorities						
Total	175	3,406	3,608	1,455	4,861	7,014
English Counties	46	1,461	2,998	1,209	2,670	4,459
English County Boroughs	79	1,317	194	98	1,415	1,511
London Boroughs	33	431	81	39	470	512
Wales	17	197	335	109	306	532

TABLE 13

Administrative and supervisory staff employed in the domiciliary midwifery service at 30th September 1968.

(England and Wales)

	Whole-time	Part-time	Whole-time equivalent of		Total number of staff
			Part-time	All staff	
All authorities					
Total	100	347	129	229	447
English Counties	11	207	77	88	218
English County Boroughs	69	59	19	88	128
London Boroughs	16	48	21	37	64
Wales	4	33	12	16	37

TABLE 14

Age distribution of midwives practising in years 1965-1968

Age group	Percentage of total number practising		
	1967–68	1966–67	1965–66
–24	5·3	6·5	5·8
25–29	18·9	19·1	20·2
30–39	28·2	26·5	25·7
40–49	23·0	22·7	22·7
50–59	19·8	21·1	21·4
60–64	3·7	3·1	3·0
65–	1·1	1·0	1·1

TABLE 15

Total number of general practitioners 1967 and 1968

(England and Wales)

	1967	1968
All practitioners	21,305	21,410
Principals	20,427	20,515
Assistants	758	757
Trainees	120	138
All principals providing unrestricted services	19,830	19,951
Single-handed principals	4,646	4,512
Members of partnerships	15,184	15,439
All principals providing restricted services	597	564
Limited lists	529	499
Principals providing maternity services only	49	46
Others	19	19

TABLE 16

Number of principal medical practitioners

Analysis by list sizes in regions at 1st October, 1968

Included in this table are all principals providing unrestricted services and those principals providing restricted services (others)

Area	Total number of patients on lists of principals	Total number of principals	Number of principals by list size					Overall average list size
			Under 1,600	1,600–1,899	1,900–2,499	2,500–2,999	3,000 and over	
England and Wales	49,458,383	19,970	2,067	1.920	6,149	5,175	4,659	2,477
England	46,724,901	18,745	1,871	1,750	5,657	4,945	4,522	2,493
North	3,298,078	1,320	115	106	414	372	313	2,499
Yorkshire and Humberside	4,866,889	1,881	147	164	508	521	541	2,587
East Midland	3,437,463	1,304	83	88	339	412	382	2,636
East Anglia	1,595,038	690	74	92	278	140	106	2,312
South East	17,847,864	7,309	859	689	2,277	1,879	1,605	2,442
South West	3,766,771	1,699	240	282	651	360	166	2,217
West Midland	5,155,705	1,938	139	143	493	512	651	2,660
North West	6,757,093	2,604	214	186	697	749	758	2,595
Wales	2,733,482	1,225	196	170	492	230	137	2,231

TABLE 17

Maternity Medical Services (England and Wales)
Annual Summary 1968

PART A. Total number of claims paid during year

	General practitioner obstetricians	Other general practitioners	Total
1. Number of claims paid	710,712	19,053	729,765
2. Number of cases in line 1 which included a fee for an anaesthetist	1,380	6	1,386

PART B. Analysis based on 10 per cent sample of claims paid

Services for which fees were paid		Number of cases attended by:— General practitioner obstetricians	Other general practitioners	Total
1. Complete service		277,007	3,161	280,168
2. Complete ante and post-natal care, i.e. without confinement		15,077	452	15,529
3. Complete ante-natal care (see note 2)	(a) With confinement	11,613	111	11,724
	(b) Without confinement	59,994	819	60,813
4. Complete post-natal care (see note 2)	(a) With confinement	6,963	89	7,052
	(b) Without confinement	11,477	218	11,695
5. Partial ante-natal care only	(a) With confinement	2,596	112	2,708
	(b) Without confinement	105,530	5,434	110,964
6. Partial post-natal care only	(a) With confinement	3,489	21	3,510
	(b) Without confinement	18,276	872	19,148
7. Partial Ante-natal and partial post-natal care		144,763	5,320	150,083
8. Other cases (except miscarriage) including confinement only		4,155	61	4,216
9. Miscarriage		49,772	2,383	52,155
10. Total		710,712	19,053	729,765
11. Number of cases included in line 10 for which the application for services was accepted less than 6 weeks before date of confinement		9,302	239	9,541

Notes: 1. All services for which a fee was paid during the quarter are included in part A of this return.

2. Line 3 includes cases which covered partial post-natal care as well as complete ante-natal care. Similarly line 4 includes cases where partial ante-natal care was also paid for.

TABLE 18

Percentage distribution of grades of prenatal care with mortality ratio in the population.

(*Perinatal Mortality Survey—1958*)

Grade of Prenatal Care	Per cent in Population	Mortality Ratio
Hospital only	20·2	101
Hospital in part	28·5	107
Local health authority clinic throughout or in part	19·4	84
General practitioner only	11·1	126
General practitioner and midwife	18·7	73
Midwife only	0·5	62
None	0·6	537
No information	0·6	191

TABLE 19

Causes of death ascribed to pregnancy and childbirth 1957-1967

(England and Wales)

ICD No.	Cause of death	1957	1963	1964	1965	1966	1967
642	Toxaemia of pregnancy	83	43	30	38	35	43
643, 644	Antepartum haemorrhage	7	6	—	1	1	—
645	Ectopic pregnancy	22	16	21	11	17	11
646–649	Other complications of pregnancy	12	25	20	15	15	18
651	Abortion with sepsis	33	32	29	29	29	15
650, 652	All other abortions	28	17	21	23	24	19
670	Antepartum haemorrhage complicating delivery	21	11	7	12	12	7
671, 672	Postpartum haemorrhage	23	21	12	11	14	5
660, 673–678	Other deaths from delivery	57	33	44	44	48	35
682, 684	Puerperal phlebitis, thrombosis and pulmonary embolism	33	20	22	17	11	10
640, 641, 681	Other sepsis of pregnancy, childbirth and puerperium	19	8	10	5	9	3
685, 686	Puerperal toxaemia	5	3	4	10	3	1
680, 683, 687–689	Other complications of puerperium	6	8	7	5	5	5
	Total	349	243	227	221	223	172
	Total excluding abortion	288	194	177	169	170	138
	Rate per 1,000 births including abortion	0·47	0·28	0·26	0·25	0·26	0·20

TABLE 20

Consultants in obstetrics and gynaecology 1959-1968
Analysis showing actual numbers and an index of numbers

Year	Number of Consultants	Index of number of Consultants
1959	439	100
1960	444	101·1
1961	460	104·8
1962	457	104·1
1963	467	106·4
1964	485	110·5
1965	513	116·9
1966	521	118·7
1967	537	122·3
1968	555	126·4

TABLE 21

Ratio of maternity beds and obstetricians to population by N.H.S. hospitals 1968
(England and Wales)

Hospital Region	Estimated population (thousands)	Number of staffed consultant maternity beds*	Number of G.P. staffed maternity beds*	Average number of maternity beds available per million population		Obstetric consultants per million population (w.t.e.)*
				Consultant beds	G.P. beds	
Newcastle	3,092·2	1,280	244	413·9	78·9	11·4
Leeds	3,231·8	1,210	331	374·4	102·4	7·1
Sheffield	4,605·5	1,434	485	311·4	105·3	5·7
East Anglia	1,713·8	493	151	287·7	88·1	7·3
Metropolitan Regions						
North West	4,192·1	2,011	35	479·7	8·3	12·0
North East	3,397·2	1,657	143	487·8	42·1	9·7
South East	3,536·0	1,363	232	385·5	65·6	9·3
South West	3,255·0	1,472	221	452·2	67·9	11·9
Oxford	1,900·6	571	344	300·4	181·0	8·4
South Western	3,092·2	773	732	250·0	236·7	7·2
Wales	2,720·0	1,065	352	391·5	129·4	9·4
Birmingham	5,084·5	1,594	599	313·5	117·8	8·4
Manchester	4,551·6	1,667	613	366·2	134·7	9·1
Liverpool	2,256·4	1,037	107	459·6	47·4	9·6
Wessex	1,964·1	526	293	267·8	149·2	7·5

*Figures relate to all hospitals (i.e. Regional Hospital Boards and Boards of Governors).

TABLE 22

Numbers of cases of deliveries in hospital, forceps deliveries and caesarean sections for 1958-1966 (sample figures, with estimated total numbers and percentages.)

Method of Delivery	1958	1959	1960	1961	1962	1963	1964	1965	1966
Deliveries in hospital									
Number of cases included in the sample	43,500	44,495	47,337	49,900	51,750	54,244	57,075	56,863	57,112
Estimated total number	453,400	461,900	489,900	518,900	540,788	572,763	613,442	615,883	635,999
Forceps deliveries (any type)									
Number of cases included in the sample	3,157	3,248	3,507	3,898	4,192	4,448	4,816	4,739	4,762
Estimated total number	32,900	33,700	36,300	40,500	43,800	47,000	51,800	51,300	53,000
% of all deliveries in hospital	7·3	7·3	7·4	7·8	8·1	8·2	8·4	8·3	8·3
Caesarean section:									
Number of cases included in the sample	1,680	1,950	2,134	2,256	2,448	2,526	2,803	2,848	2,705
Estimated total number	17,500	20,200	22,100	23,500	25,600	26,700	30,100	30,800	30,100
% of all deliveries in hospital	3·9	4·4	4·5	4·5	4·7	4·7	4·9	5·0	4·7
% of all deliveries, England and Wales	2·3	2·6	2·8	2·8	2·9	3·1	3·4	3·5	3·5

TABLE 23

N.H.S. hospitals in-patient maternity services. Antenatal, delivery and postnatal care 1958-1966

	Unit	1958	1959	1960	1961	1962	1963	1964	1965	1966
Spells of:										
Antenatal care only	thousands	57·8	56·7	63·4	71·5	74·8	81·5	85·3	90·1	94·0
Antenatal care followed by delivery and postnatal care	thousands	90·0	90·4	106·5	114·3	132·8	141·9	149·3	160·4	170·4
Delivery and postnatal care only	thousands	363·4	371·5	383·4	404·6	408·0	430·8	464·1	455.5	465·6
Post-natal care without delivery in that unit	thousands	13·5	14·2	13·6	15·5	18·2	22·1	23·0	25·6	28·1
Average length of stay:										
Antenatal (1)	days	4·3	4·2	4·1	4·2	4·3	4·2	4·0	4·0	3·9
Postnatal	days	9·6	9·3	9·0	8·4	8·1	7·8	7·4	7·2	6·9
Percentage of all women whose postnatal stay was:										
Under 3 days	per cent	4·9	5·8	6·1	7·4	9·0	10·2	11·9	13·0	14·8
3–4 days	per cent	3·1	3·6	4·1	—	5·5	6·7	8·3	9·8	11·2
5–6 days	per cent	4·0	4·3	4·9	—	7·6	9·2	11·0	12·5	13·3
7–8 days	per cent	56·9	59·7	64·1	—	64·6	62·3(2)	28·2(2)	27·8(2)	27·9
9–10 days	per cent						(2)	30·6(2)	27·8(2)	24·7
11 or more days	per cent	31·1	26·5	20·8	15·7	13·4	11·6	9·9	9·0	8·1

Notes: Figures are estimated from a sample and are subject to sampling error.
1. Combines all spells of antenatal care with or without delivery.
2. Estimated from incomplete sample data.

Table 24

Doctors in obstetrics and gynaecology at 30th September 1968

Analysis by employing authority and grade showing number of staff and whole-time equivalent

Employing Authority	Consultant		S.H.M.O. with allowance		S.H.M.O. without allowance		Medical Assistant		Senior Registrar		Registrar		J.H.M.O.		S.H.O.		H.O. Post-reg.		H.O. Pre-reg.		Ungraded Staff		Para. 94 appts. (1)	
	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE	No.	WTE
All Authorities:																								
Total without duplication (2)	555	436·3	5	1·6	13	5·8	18	16·5	85	79·0	407	400·1	2	2·0	565	562·9	197	197·0	87	86·3	4	1·6	399	66·0
Total of figures shown below	632	436·3	5	1·6	13	5·8	18	16·5	86	79·0	407	400·1	2	2·0	565	562·9	197	197·0	87	86·3	4	1·6	402	66·0
Regions:																								
Newcastle R.H.B.	36	30·8	—	—	1	1·0	—	—	2	2·0	26	26·0	—	—	53	52·3	—	—	—	—	—	—	21	5·1
United Newcastle	8	4·6	—	—	—	—	—	—	1	1·0	3	3·0	—	—	6	5·6	—	—	—	—	1	0·6	—	—
Leeds R.H.B.	27	20·1	—	—	—	—	1	1·0	2	2·0	20	20·0	—	—	39	39·0	8	8·0	1	1·0	—	—	23	5·6
United Leeds	6	2·9	—	—	—	—	—	—	3	2·5	1	1·0	—	—	8	8·0	—	—	—	—	—	—	—	—
Sheffield R.H.B.	32	23·4	1	0·4	—	—	1	1·0	2	2·0	23	23·0	—	—	55	55·0	—	—	—	—	—	—	40	7·5
United Sheffield	6	2·9	—	—	—	—	—	—	2	2·0	1	1·0	—	—	6	6·0	—	—	2	2·0	—	—	—	—
East Anglian R.H.B.	16	11·3	—	—	—	—	—	—	1	1·0	9	9·0	—	—	16	16·0	2	2·0	—	—	—	—	8	2·0
United Cambridge	2	1·2	—	—	—	—	—	—	1	1·0	2	2·0	—	—	3	3·0	1	1·0	—	—	—	—	—	—
N.W. Met. R.H.B.	50	33·5	—	—	—	—	3	2·6	4	4·0	35	34·6	—	—	43	43·0	24	24·0	5	5·0	—	—	35	5·2
N.E. Met. R.H.B.	40	28·1	1	0·5	1	0·6	3	3·0	—	—	34	33·0	—	—	32	32·0	19	19·0	14	14·0	—	—	16	1·7
S.E. Met. R.H.B.	36	27·8	1	0·3	—	—	1	1·0	3	3·0	18	18·0	—	—	23	23·0	10	10·0	16	16·0	—	—	19	3·0
S.W. Met. R.H.B.	40	27·0	—	—	—	—	—	—	4	3·5	27	26·6	—	—	26	26·0	18	18·0	5	5·0	—	—	23	4·5
Oxford R.H.B.	18	12·4	—	—	6	1·3	1	0·3	1	1·0	11	11·0	1	1·0	14	13·6	3	3·0	1	1·0	—	—	16	3·1
United Oxford	5	3·5	—	—	—	—	—	—	2	2·0	6	4·4	—	—	—	—	8	8·0	—	—	—	—	—	—
South Western R.H.B.	28	20·3	1	0·4	—	—	4	3·5	2	2·0	12	12·0	—	—	24	24·0	13	13·0	1	1·0	—	—	33	5·1
United Bristol	4	2·0	—	—	—	—	—	—	3	2·0	1	1·0	—	—	2	2·0	1	1·0	2	2·0	—	—	—	—
Welsh H.B.	29	23·4	—	—	2	1·5	1	1·0	2	2·0	16	16·0	—	—	34	34·0	9	9·0	2	2·0	—	—	29	3·4
United Cardiff	4	2·1	—	—	—	—	—	—	4	3·6	5	4·1	—	—	2	1·4	2	2·0	1	1·0	—	—	1	0·0
Birmingham R.H.B.	48	37·9	—	—	2	1·3	2	2·0	3	3·0	30	30·0	—	—	52	52·0	11	11·0	5	4·6	—	—	35	6·8
United Birmingham	7	5·0	—	—	—	—	—	—	5	3·0	5	5·0	—	—	7	7·0	1	1·0	2	2·0	1	0·0	2	0·2
Manchester R.H.B.	47	37·3	1	0·1	—	—	—	—	3	3·0	32	32·0	1	1·0	45	45·0	19	19·0	8	8·0	—	—	29	3·2
United Manchester	6	4·0	—	—	—	—	—	—	3	3·0	7	7·0	—	—	10	10·0	1	1·0	—	—	2	1·0	16	1·3
Liverpool R.H.B.	26	17·9	—	—	—	—	1	1·0	1	1·0	20	20·0	—	—	13	13·0	11	11·0	2	2·0	—	—	16	2·7
United Liverpool	7	3·8	—	—	—	—	—	—	2	2·0	6	5·2	—	—	5	5·0	1	1·0	—	—	—	—	—	—
Wessex R.H.B.	19	14·8	—	—	—	—	—	—	3	3·0	15	15·0	—	—	10	10·0	13	13·0	1	1·0	—	—	20	2·5

U.G. Hospitals:																								
St. Bartholomew's	4	2·0	—	—	—	—	—	—	1	1·0	2	2·0	—	—	—	—	2	2·0	2	2·0	—	—	—	—
London	5	2·7	—	—	—	—	—	—	1	1·0	4	4·0	—	—	1	1·0	2	2·0	3	3·0	—	—	5	0·5
Royal Free	5	2·8	—	—	1	0·2	—	—	3	2·5	3	2·6	—	—	2	2·0	2	2·0	—	—	—	—	3	1·1
University College	6	2·8	—	—	—	—	—	—	2	1·3	3	1·5	—	—	4	4·0	—	—	—	—	—	—	7	0·8
Middlesex	4	2·2	—	—	—	—	—	—	1	1·0	3	3·0	—	—	—	—	—	—	1	1·0	—	—	—	—
Charing Cross	5	1·9	—	—	—	—	—	—	1	1·0	2	2·0	—	—	2	2·0	—	—	4	3·6	—	—	4	0·4
St. George's	3	1·8	—	—	—	—	—	—	2	1·5	2	2·0	—	—	—	—	4	4·0	—	—	—	—	—	—
Westminster	4	2·5	—	—	—	—	—	—	3	3·0	2	2·0	—	—	3	3·0	—	—	1	1·0	—	—	—	—
St. Mary's	9	4·2	—	—	—	—	—	—	1	1·0	6	6·0	—	—	2	2·0	3	3·0	3	3·0	—	—	—	—
Guy's	5	1·7	—	—	—	—	—	—	1	1·0	1	1·0	—	—	2	2·0	1	1·0	1	1·0	—	—	1	0·4
King's College	6	3·4	—	—	—	—	—	—	—	—	3	3·0	—	—	2	2·0	4	4·0	3	3·0	—	—	—	—
St. Thomas'	6	3·2	—	—	—	—	—	—	3	2·6	2	2·0	—	—	4	4·0	4	4·0	1	1·0	—	—	—	—
P.G. Hospitals:																								
Hammersmith	6	2·8	—	—	—	—	—	—	3	3·0	5	5·0	—	—	9	9·0	—	—	—	—	—	—	—	—
Sick Children	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Nervous Diseases	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Royal Nat. T. N. & E.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Moorfields	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Bethlem & Maudsley	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
St. John's for Skin	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Diseases of the Chest	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Royal Nat. Orthopaedic	1	0·1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
National Heart	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
St. Peter's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Royal Marsden	2	0·3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Charlotte's	14	3·8	—	—	—	—	—	—	5	4·5	4	4·0	—	—	6	6·0	—	—	—	—	—	—	—	—
Eastman Dental	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

Notes: The table includes all staff holding permanent paid (whole-time and part-time) and honorary appointments in the N.H.S. hospital service in England and Wales. Staff holding locum appointments only are excluded. Staff holding appointments with more than one employing authority are included separately under each authority. Staff holding more than one appointment in different grades with one authority are included in each grade. Staff holding more than one appointment in the same grade with one authority are generally included once only.

Due to rounding the W.T.E. totals do not necessarily correspond precisely with the sum of the detailed figures.

(1) Staff (mainly general practitioners) engaged in hospital work to whom paragraph 94 of the Terms and Conditions of Service of Hospital Medical and Dental Staff apply.

(2) In this total staff holding two or more appointments whether with the same or different employing authorities are counted once only in the higher grade.

TABLE 25

Registrars in obstetrics and gynæcology at 30th September 1968. Analysis by number of years since first entry to the grade

Country of birth	Total	Years since first entry to the grade				
		less than 1	1 but less than 2	2 but less than 3	3 but less than 4	4 years and over
Total	407	135	116	71	37	48
Born G.B., N.I., or Republic of Ireland	159	59	38	26	20	16
Born Overseas	248	76	78	45	17	32

TABLE 26

COMPARISON OF ESTIMATED NUMBERS IN TRAINING GRADES (BORN IN GREAT BRITAIN OR IRISH REPUBLIC) TO ESTIMATED CONSULTANT VACANCIES (ALL COUNTRIES OF BIRTH) FOR OBSTETRICS AND GYNAECOLOGY

ESTIMATES BASED ON NUMBER OF STAFF IN POST AT SEPTEMBER 1968

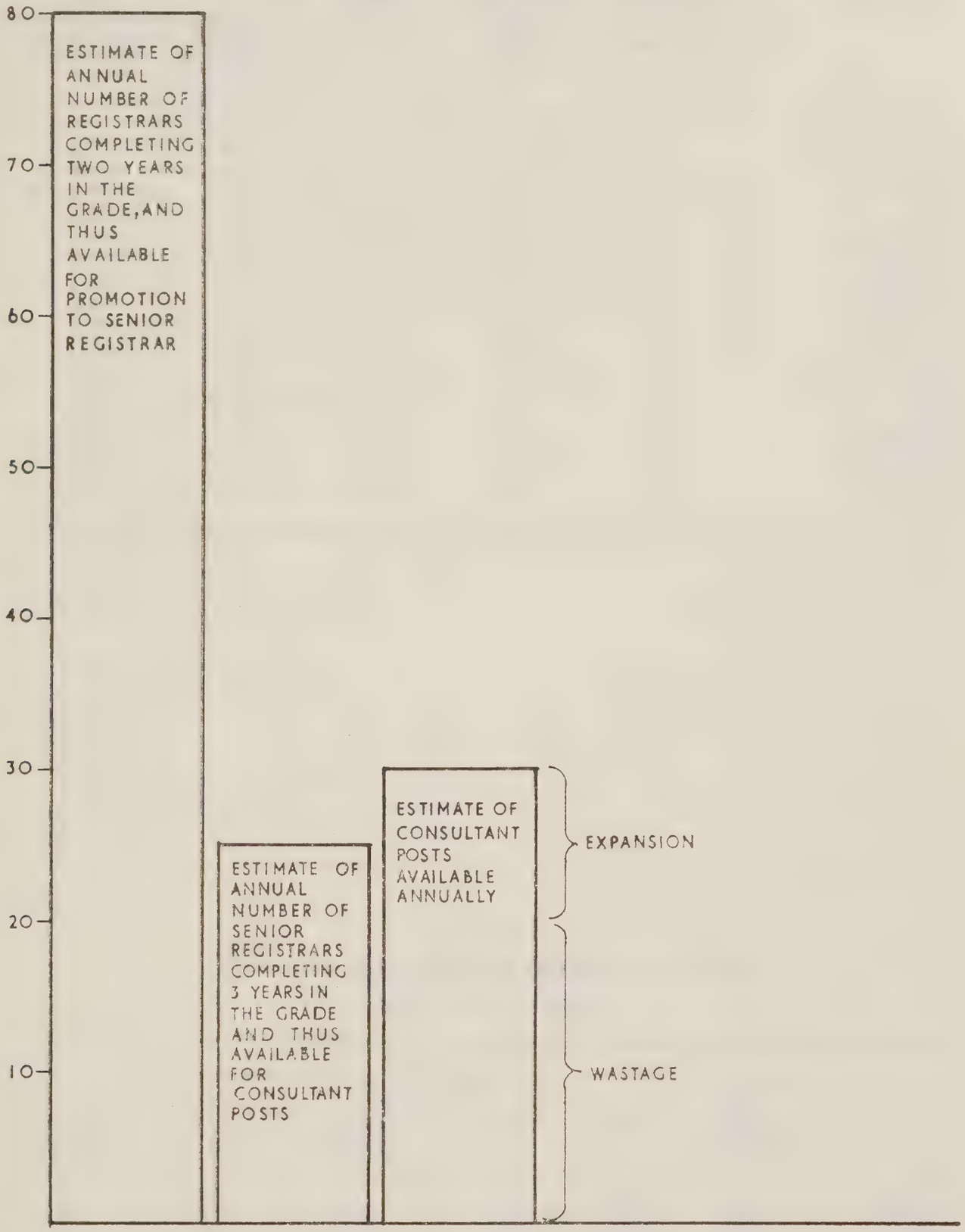


TABLE 27

Staffed maternity beds—1967 and throughput in relation to the institutional and hospital confinement rates.

Area	Staffed Beds per 1,000 population female age 15–44	Staffed Beds per 1,000 live and still births in NHS hospitals	Throughput (cases treated per available bed per year)	Live and still births in institutions (NHS and other) as percentage of total births	Live and still births in NHS hospitals as percentage of total births
1	2	3	4	5	6
England and Wales	2·4	35·4	35·6	77·8	75·4
Newcastle	2·5	37·9	35·2	77·5	75·4
Leeds	2·5	34·9	35·4	78·4	77·6
Sheffield	2·1	32·5	39·8	71·9	69·0
East Anglian	1·8	33·1	39·1	67·1	60·6
N.W. Met.	2·4	33·6	31·7	80·8	77·9
N.E. Met.	2·8	43·3	31·6	76·8	75·2
S.E. Met.	2·3	37·7	31·8	76·8	74·9
S.W. Met.	2·5	37·0	33·5	85·2	79·2
Oxford	2·4	32·4	41·0	80·9	77·0
South Western	2·6	37·1	35·0	80·3	78·2
Wales	2·8	37·8	34·6	86·4	85·4
Birmingham	2·1	31·8	39·8	72·2	71·5
Manchester	2·5	34·4	36·6	78·0	77·3
Liverpool	2·6	34·6	35·4	82·7	81·3
Wessex	2·1	34·5	37·7	76·5	70·0

TABLE 28

Infant and neonatal mortality rates 1951-1967

(England and Wales)

Year	Live birth rates per 1,000 population	Infant mortality rates per 1,000 live births				
		Total	1st day	Rest of 1st week	7 days–4 weeks	4 weeks–3 months
1951–1955	15·2	26·9	7·5	7·5	3·0	3·4
1956–1960	16·4	22·6	7·5	6·3	2·4	2·6
1964	18·5	19·9	7·1	4·9	1·8	2·4
1966	17·7	19·0	6·5	4·6	1·7	2·5
1967	17·2	18·3	6·3	4·4	1·8	2·4

TABLE 29

Domiciliary midwives: part-time workers—vacancies and wastage 1967

		English County Councils	English County Boroughs	London Boroughs	Wales	England and Wales
	Number of authorities in survey	42	76	32	17	167
A	*Part-time midwives not employed by the authority on any other nursing duties at 30th September 1967.*					
	Number of midwives	112	161	37	12	322
	Number of authorities	27	36	14	2	79
B	*Vacancies for domiciliary midwives at 30th September 1967.*					
	Whole-time equivalent of vacancies	237	117	34	40	428
	Number of authorities with vacancies.					
	Total	39	34	16	10	99
	All persisting for less than 3 months	3	3	2	—	8
	Some persisting for 3–5 months	23	11	7	2	43
	Some persisting for 6–11 months	18	11	8	4	41
	Some persisting for more than 12 months	16	13	6	10	45
C	*Wastage of domiciliary midwives.*					
	Number who left during year 1967 giving reasons.					
	Total	432	169	65	45	711
	Retirement	113	36	6	17	172
	Domestic	176	64	30	16	286
	Insufficient congenial work	14	2	2	3	21
	Other known reasons	116	66	26	9	217
	Reasons unknown	13	1	1	—	15

TABLE 30

Deliveries attended by domiciliary midwives 1967

		English County Councils	English County Boroughs	London Boroughs	Wales	England and Wales
	Number of authorities in survey	42	76	32	17	167
A	*Number of confinements attended under N.H.S. arrangements Jan.–Sept. 1967.*					
	Total	72,068	43,699	15,654	4,938	136,359
	At home	71,274	43,310	15,625	4,631	134,840
	In hospitals	786	212	22	304	1,324
	Other	8	177	7	3	195
B	Number of domiciliary midwives who delivered patients in hospital	87	47	12	27	173
	Number of authorities recording such deliveries	12	4	2	4	22
C	*Number of midwives who attended 5 or less deliveries Jan.-Sept. 1967.*					
	Part-time midwives not employed by the Authority on other nursing duties	62	127	30	1	220
	All others (including district nurse/midwives etc.)	756	42	14	289	1,101
D	*Deliveries attended annually per domiciliary midwife.*					
	Average number:	(†)23	39	38	12	27
	Number of authorities recording the following:					
	Under 20 deliveries annually	26	6	3	14	49
	21–30 ,, ,,	9	10	5	2	26
	31–40 ,, ,,	7	29	12	1	49
	41–50 ,, ,,	—	21	10	—	31
	51–60 ,, ,,	—	6	1	—	7
	Over 60 ,, ,,	—	4	1	—	5
E	*Minimum number of deliveries a domiciliary midwife should attend to retain her skills in delivery.*					
	Number of authorities replying—Total	40	69	28	15	152
	Opinions given:					
	(15 authorities did not answer this question).					
	1–10 confinements annually	5	—	2	4	11
	11–20 ,, ,,	25	19	5	6	55
	21–30 ,, ,,	10	26	13	4	53
	30–40 ,, ,,	—	8	2	—	10
	Over 40 ,, ,,	—	16	6	1	23

(†) Based on annual rate of deliveries during Jan.–Sept. 1967 and actual number of midwives at 30th September, 1967.

TABLE 31

Cases discharged from hospital visited by domiciliary midwives 1967

		English County Councils	English County Boroughs	London Boroughs	Wales	England and Wales
	Number of authorities in Survey*	42	76	32	17	167
A	*Women discharged from hospital who received their first postnatal visit by domiciliary midwives during three months July–September 1967*					
	Total numbers of women	39,173	29,456	4,816	7,141	80,586
	Totals for whom days after delivery were known:	27,944	28,731	3,810	7,141	67,626
	(a) Discharged within 48 hr. after delivery	4,784	3,592	1,246	784	10,406
	(b) „ „ 2–4 days „ „	7,175	6,687	1,648	1,832	17,342
	(c) „ „ 5–7 days „ „	6,999	10,209	690	2,880	20,778
	(d) „ „ 8–10 „ „ „	8,109	7,313	210	1,356	16,988
	(e) „ „ 11 or more „ „	877	930	16	289	2,112
	Percentages of totals for whom days after delivery were known:					
	Discharged within:—					
	(a) 48 hours after delivery	17	13	33	11	15
	(b) 2–4 days „ „	26	23	43	26	26
	(c) 5–7 days „ „	25	35	18	40	31
	(d) 8–10 days „ „	29	26	6	19	25
	(e) 11 or more days „	3	3	0	4	3
B	Women resident in authorities' areas who were delivered in hospitals and other institutions during July–Sept. 1967 (estimated)	71,552	43,777	27,751	9,541	152,621
C	Women visited as percentages of total delivered in hospital etc. (Total of A. above as percentage of B.)	55	67	17	75	53
D	Estimated deliveries in hospitals etc. as percentage of all deliveries for women resident in areas July-Sept. 1967	75	75	84	86	77
E	*Employment of midwives solely on postnatal visits to "early discharge" cases*					
	Number so employed on Sept. 30th, 1967	20	70	28	13	131
	Number of others who would be prepared to do only this	625	167	59	216	1,067

*18 Authorities were unable to give the full breakdown (a) to (e).

TABLE 32

Training in domiciliary midwifery at 30th September, 1967

		English County Councils	English County Boroughs	London Boroughs	Wales	Total
	Number of authorities in survey	42	76	32	17	167
A	*Authorities responsible for complete part II training*					
	(a) Number of responsible authorities	3	18	2	2	25
	(b) Number which will arrange training for other areas' pupils	1	11	1	1	14
	(c) Places available per year	60	411	76	56	603
	(d) Number of approved midwife teachers	23	195	16	17	251
B	*Authorities not responsible for complete part II training*					
	(a) Number of authorities which accept pupils	35	55	30	5	125
	(b) Number which accept pupils from hospitals in					
	(i) authority's area	29	44	22	4	99
	(ii) other areas	19	15	20	3	57
	(c) Number of places provided for pupils in					
	(i) authority's area	947	1,521	573	122	3,163
	(ii) other areas	296	296	332	—	924
	(d) number of approved midwife teachers	542	557	263	50	1,412

TABLE 33

Changes in deployment of midwives

(*extracted from replies to question 19 in appendix E—questionnaire issued October 1967*)

		English County Councils	English County Boroughs	London Boroughs	Wales	Total
	Total number of authorities in survey	42	76	32	17	167
A	Number of authorities which reported changes in deployment	41	38	17	11	107
B	Number which used the following methods:—					
	(a) Redundancy	12	6	6	2	26
	(b) Extension of home nursing duties	23	3	3	5	34
	(c) Alteration of range of duties	27	20	8	6	61
	(d) Other methods	23	24	9	6	62
C	Number of authorities where changes in deployment were associated with a higher institutional confinement rate	32	35	15	7	89
D	Number of authorities which had a change in the range of midwifery duties other than increase in work with "early discharge" cases	22	29	8	8	67

TABLE 34

The number and distribution of general practitioner beds available for maternity cases at 31st March 1968.

Region	In same ward as consultant beds	Close to Consultant ward	Separated from Consultant ward	Completely separate G.P. Unit		Total
				Number	%	
TOTAL	320	442	276	4,107	80	5,102
Newcastle	83	—	66	205	58	354
Leeds	30	46	33	295	82	361
Sheffield	36	79	—	390	77	505
East Anglia	—	16	—	144	90	160
N.W. Met.	—	12	—	36	75	48
N.E. Met.	—	22	32	102	65	156
S.E. Met.	25	10	—	218	86	253
S.W. Met.	40	21	—	152	71	213
Oxford	16	26	14	268	83	324
S. Western	48	43	17	626	85	734
Wales	—	—	20	362	95	382
Birmingham	—	158	43	411	67	612
Manchester	17	9	41	545	89	612
Liverpool	17	—	10	79	75	106
Wessex	8	—	—	274	97	282

TABLE 35

Regional distribution of maternity hospitals with existing or possible catchment areas

(extracted from replies to question 4 in Appendix G—questionnaire issued April 1968)

Region	Total number of maternity hospitals	Number with catchment areas	Number where catchment areas could be defined	Other maternity hospitals
Total	651	256	141	254
Newcastle	42	24	—	18
Leeds	41	14	27	—
Sheffield	60	10	50	—
East Anglia	24	—	—	24
N.W. Met.	34	16	18	—
N.E. Met.	41	15	8	18
S.E. Met.	43	14	26	3
S.W. Met.	46	25	12	9
Oxford	30	—	—	30
S. Western	66	66	—	—
Wales	59	19	—	40
Birmingham	55	—	—	55
Manchester	59	14	—	45
Liverpool	21	9	—	12
Wessex	30	30	—	—

TABLE 36

Summary of personnel comprising the "Flying Squads" who went out in answer to their most recent emergency calls

(*extracted from replies to question 3 of Appendix A to Appendix G—questionnaire issued April 1968*)

Consultant	58
Registrar	115
House Officer	72
Anaesthetist	49
General Practitioners	1
Midwife/nurse	146
Medical student	28
Pupil midwife	2

TABLE 37

Journeys incurred by emergency obstetric services

(*extracted from replies to question 2 of Appendix A to Appendix G—questionnaire issued April 1968*)

Duration of outward journey

Minutes	No. of squads recording	
	Average	Maximum
Under 10	12	11
10–20	101	
21–30	36	43
31–45	10	46
46–60	7	35
Over 60		27
Not known	29	33

TABLE 38

Length of outward journey

Miles	No. of squads recording	
	Average	Maximum
Under 3	12	37
3–5	65	
6–10	71	
11–15	20	53
16–20	6	33
21–30		36
Over 30		13
Not known	21	23

TABLE 39

Calls received by emergency obstetric services in 1967*

Type of case	*Domiciliary*	*G.P. Unit*	*Other*
Abortion	314	5	1
Antenatal	391	27	11
Delivery	840	225	8
Postnatal	895	149	38
Total	2,440	406	58

*Incomplete returns, which relate to only 175 squads.

TABLE 40

The employment of domiciliary midwives in hospital

(*extracted from replies to question 7 in Appendix G—questionnaire issued April 1968*)

(*a*) The number of hospitals where domiciliary midwives undertake deliveries	51
(*b*) Number of midwives involved (whole-time equivalent)	216
(*c*) Number of cases delivered	1994
(*d*) Number included in (*b*) doing work which could otherwise be done by hospital midwives on the establishment	65
(*e*) Number included in (*b*) who are necessarily helping to staff hospitals	31

Note: The majority of cases delivered (item *c*) were concentrated in the following regions:

Oxford	736	S.W. Met.	338	Birmingham	138
Wales	426	Manchester	280	S. Western	59

TABLE 41

The employment of hospital midwives solely on special duties

(*extracted from replies to question 8 in Appendix G—questionnaire issued April 1968*)

	Whole-time staff	Part-time staff	Total
Antenatal	371	267	638
Delivery	796	206	1,002
Postnatal	627	238	865
Special care baby units	380	115	495
Milk kitchens	26	24	50
Total	2,200	850	3,050

TABLE 42

Number of hospitals with midwifery staff vacancies of varying degrees of persistence at 31st March 1968.

Vacancies persisting for under 3 months	136
,, ,, ,, 3 to 6 months	103
,, ,, ,, 6 to 12 months	120
,, ,, ,, 12 months or more	185

Total number of hospitals—365.

TABLE 43

Summary of reasons given by hospital midwives for leaving their employment during 1967.

Retirement	112
Domestic Reasons	1,243
Insufficient Congenial Work	48
Other Reasons	990
Reason not known	156

TABLE 44

Places available and taken up in midwifery training schools—1967

Region	Training Schools			Places provided				Number accepted for training	
				Places		Intakes			
	Part I	Part II	Combined	Part I	Part II	Part I	Part II	Part I	Part II
Total E. & W.	83	116	74	5,722	4,224	1,170	857	5,811	3,780
Newcastle	5	9	4	238	174	23	53	259	145
Leeds	4	4	6	268	99	16	8	304	109
Sheffield	3	10	5	314	311	39	57	339	292
E. Anglia	2	2	1	127	76	4	4	119	48
N.W. Met.	3	5	12	708	552	56	60	661	529
N.E. Met.	9	4	8	898	472	255	86	787	346
S.E. Met.	6	7	7	553	352	225	145	550	395
S.W. Met.	11	10	4	645	454	56	40	711	352
Oxford	4	9	—	150	198	12	33	131	175
S. Western	2	4	4	271	204	214	93	380	195
Wales	5	7	3	170	132	99	59	199	113
Birmingham	5	9	8	250	212	51	60	411	306
Manchester	14	13	6	482	†485	82	100	439	‡384
Liverpool	8	11	3	550	306	28	24	403	247
Wessex	2	12	3	98	197	10	35	118	144

†includes 80 integrated courses

‡includes 51 integrated courses

APPENDICES

APPENDIX A

HEALTH SERVICES AND PUBLIC HEALTH ACT 1968

Section 10

Health Services provided by local Health Authorities

MIDWIFERY SERVICES

Section 10 of the 1968 Act repeals Section 23 (Midwifery) of the National Health Service Act 1946 which is replaced by the following provisions:

Section 10–(1) "It shall be the duty of every local health authority to secure, whether by making arrangements with Boards of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of such midwives so employed who are available in the authority's area for attendance on women in their homes as midwives is adequate for the needs of the area and that the midwives so available as aforesaid are enabled to render all services reasonably necessary for the proper care of the women upon whom they so attend.

(2) A local health authority may make provision in their area in manner aforesaid for the attendance on women, elsewhere than in their homes or in hospitals vested in the Minister, as midwives of certified midwives so employed.

(3) A local health authority may make arrangements with a Hospital Management Committee exercising functions with respect to the management and control of a hospital or with a Board of Governors exercising functions with respect to the administration of a teaching hospital for there to be made available in the hospital, on such terms and conditions as may be agreed, the services of certified midwives employed by the authority for the purposes of either of the two foregoing subsections and may make arrangements with another local health authority for there to be made available in that other authority's area, on such terms and conditions as may be agreed, the services of such midwives as aforesaid."

APPENDIX B

NATIONAL HEALTH SERVICE
MATERNITY MEDICAL SERVICES

1. The Minister of Health, in agreement with the representatives of the profession, has reconsidered the conditions set out in E.C.N. 347 required by a doctor applying to the Local Obstetric Committee for inclusion in the obstetric list, and has made certain changes as will be seen in (i), (vi) and (vii) below. These are not however major changes and are more in the nature of clarification. They do not apply to doctors already included in the list. The Minister now determines for the purposes of Regulation 2(1) of the National Health Service (General Medical and Pharmaceutical Services) Regulations 1962 that on or after 1st October 1966 the applicant will be required to satisfy one of the following conditions; he shall:

(i) have within the period of ten years previous to the date of application for approval of his experience, held a six months' resident appointment in an obstetric unit in a hospital in the United Kingdom or the Republic of Ireland or held a similar appointment in an obstetric unit in a British Armed Forces hospital outside the United Kingdom. Such an appointment shall include:

(*a*) a joint post in an obstetric and gynaecological unit or a joint post in an obstetric and paediatric unit, or

(*b*) rotating internships between obstetric and gynaecological units in one or more hospitals.

if, in the opinion of the Local Obstetric Committee, the applicant spent sufficient time in obstetrics; or

(ii) where he has held a resident appointment as described in condition (i) above but not within ten years of the date of application, have attended within five years previous to the date of application a refresher course in obstetrics of not less than one week provided under Section 48 of the National Health Service Act, 1946, of the National Health Service (Scotland) Act, 1947 or the Health Services Act, 1948 (Northern Ireland), by a University or Medical School in the United Kingdom or a refresher course of similar standard approved by such a University or School; or spent not less than two weeks working as a resident obstetric officer in an obstetric unit in the United Kingdom under the supervision of a consultant; or

(iii) have been within the period of two years previous to the date of application on the obstetric list of the same or another Executive Council and at the time of leaving it could have qualified for admission to it under (i) or (ii) above; or

(iv) have been a principal in obstetric practice in the United Kingdom involving attendance in the five years previous to the date of application on not less than 100 maternity cases for which he has been responsible for antenatal care in all, and supervision of labour and the puerperium in at least 50; or

(v) be at the time of application on another obstetric list in England or Wales; or

(vi) have had within the two years previous to the date of application experience in an obstetric unit under a consultant obstetrician in a hospital in the United Kingdom; this experience, some of which may have been gained in a resident

clinical attachment in the same or another consultant obstetric unit, should have involved regular work in the obstetric unit or units during six consecutive months within the two year period and should include:

(*a*) not less than 20 normal deliveries, and

(*b*) attendance at not less than 10 abnormal confinements, and

(*c*) attendance at not less than 10 antenatal and two postnatal clinics; or

(vii) have had experience which the Minister on the recommendation of a Local Obstetric Committee and after consultation with the representative of the profession approves as acceptable experience in the light of the above conditions.

2. The chief effect of the new conditions is to include in (i) above experience gained in hospitals in the Republic of Ireland or with the British Armed Forces; to restrict the experience described at (iv) to that gained as a principal; and to provide at (vi), exceptionally, for some resident experience to count as an alternative to the more usual non-resident experience.

APPENDIX C

GENERAL PRACTITIONER OBSTETRIC BEDS IN A CONSULTANT UNIT

Oldershaw and Brudenell (1968)

Oldershaw and Brudenell (1968) describe the first 500 deliveries or so supervised by general practitioners in Consultant Obstetric Units of Dulwich and St. Giles' Hospitals. The scheme was initiated following discussions at the local maternity liaison committees. Only general practitioners on the obstetric list were invited to attend; only women with unsuitable home conditions and fulfilling the criteria for confinement in a general practitioner maternity unit were accepted. The consultant obstetrician retained sole responsibility for the patients; the general practitioner working under his general direction. Initially 80 general practitioners applied to use beds; eventually only 25 doctors in 14 practices made use of the scheme. Each general practitioner had an honorary contract with the hospital.

Antenatal Care

The initial antenatal examination is performed by the general practitioners. Blood is taken for routine testing and a chest X-ray is arranged. The results are entered on a co-operation card (MCW 266) and bearing this card the patient attends the hospital booking clinic. Details are entered in the hospital records. The patient then attends the general practitioner for antenatal care until the 34th week when she returns to the hospital to be seen by the consultant or his registrar and her continuing suitability for g.p. care is confirmed.

During Labour and Puerperium

At the onset of labour the patient is admitted to hospital and the general practitioner informed. Responsibility for the management of labour rests with the general practitioner who is expected to be present at the confinement when possible. The patient is under the general practitioner's care during the puerperium. He is also responsible for the care of the baby under the direction of the consultant paediatrician. The postnatal examination is carried out by the general practitioner at his surgery.

Attendance of general practitioner at Delivery

The general practitioner was present at 175 (40 per cent) of a possible 436 deliveries, i.e. after excluding cases previously handed over to consultant care. Doctors in partnership could attend a higher percentage of deliveries than single handed ones.

Perinatal Mortality

The authors point out that a perinatal mortality rate of 12 per 1,000 for patients under general practitioner care in the review is encouraging; Hobbs and Acheson (1966) found the perinatal mortality rate in such cases to be as high as 82 per 1,000.

Abnormalities necessitating transfer to consultant care arose in 12 per cent of this specially selected low risk group and transfer to hospital would have been necessary for half as many again had they been booked for home delivery.

Rhodes (1968)

Rhodes (1968) outlines a scheme by which the St. Thomas' Hospital Board of Governors agreed to make available to general practitioners in the area four beds in the Consultant Maternity Unit at Lambeth Hospital. The scheme was limited to 12 doctors

who were offered and accepted an honorary contract with the Board of Governors. In other organisational respects it resembled that described by Oldershaw and Brudenell (1968).

A review following 2 years' working shows that there were only 86 deliveries compared with an expected 150. Of the 86 patients 41 were visited during the first stage of labour by their booked doctors but 20 of those were by one doctor, who looked after 47 patients out of 86. In 9 cases there was great difficulty in contacting the doctor and in 4 others the doctor told the labour ward staff that he was not to be called further about his patient. (The increasing use of the emergency call service makes it difficult to get in touch with general practitioners on their days off).

Rhodes points out that general practitioners over-estimated their needs and underestimated their difficulties in getting to see their patients during labour and delivery. There has, however, been inestimable value to the patients in the continuity of antenatal care and visits to them by their doctors while in hospital. Also their postnatal care has been so much better because of the close personal attention of their own doctors. The author stresses the need to appraise the ability and willingness of general practitioners to attend women in labour when they know they will be cared for, in any case, by the hospital staff.

APPENDIX D

DOMICILIARY OBSTETRICS IN A GROUP PRACTICE

Hudson (1968) describes domiciliary obstetrics by a group of four general practitioners in a review period from January 1960 to December 1966. The survey was retrospective based on midwives records; the object was to assess the success of selection of women for home delivery and pin-point errors of judgement. In the review period there were 1,465 pregnancies exceeding 28 weeks gestation; 667 or 45 per cent were initially booked for home confinement.

Of the 667 women booked for home confinement, 83 per cent were eventually delivered at home, 12·1 per cent developed complications in the antenatal period which required hospital delivery and 4·1 per cent were transferred to hospital in labour. 60 primigrafidae were booked for home confinement but 40 per cent required transfer to hospital either before or during labour. The majority of transfers in labour were due to delay in the first and second stages or of foetal distress.

The author points out that the outstanding fact which emerged from the survey is the high rate of transfer of primigravidae both before and during labour which indicates that they should all be booked for confinement in specialist units. Further, the low incidence of complications in home delivered patients and the low perinatal mortality rates, i.e. 5·4 per 1,000 demonstrate that conscientious antenatal care and careful initial selection of cases for place of confinement provide a high degree of safety for home deliveries.

APPENDIX E

QUESTIONNAIRE ON THE DOMICILIARY MIDWIFERY SERVICE

CENTRAL HEALTH SERVICES COUNCIL

STANDING MATERNITY AND MIDWIFERY ADVISORY COMMITTEE

SUB-COMMITTEE TO CONSIDER THE FUTURE OF THE DOMICILIARY MIDWIFERY SERVICE

.....Local Health Authority

QUESTIONNAIRE ON THE DOMICILIARY MIDWIFERY SERVICE

Employment of Midwives

1. (*a*) Number of domiciliary midwifery staff employed on September 30th 1967 (include those employed by voluntary organisations, H.M.C.'s or B.G.'s as on LHS 27/9 Part A lines 1, 2 and 3).

Administrative and supervisory				Domiciliary Midwives			
Whole-time (1)	Part-time (2)	Whole-time equivalent of (2) (3)	Vacancies at 30.9.67 (W.T.E.)	Whole-time (4)	Part-time (5)	Whole-time equivalent of (5) (6)	Vacancies at 30.9.67 (W.T.E.)

(*b*) Is a non-medical supervisor employed? ..... Yes/NoØ

(*c*) If so, is she engaged full-time on statutory supervisory duties? (SRO.1937 No. 398) Yes/NoØ

If none, write none

2. How many of the midwives shown in question 1, column (5) were *not* employed by the Authority on any other nursing duties?

3. How many domiciliary midwives deliver patients in hospital?*

4. How many domiciliary midwives are attached to General Practices? (i.e. their allotted patients are those of the practice and not those of the area)

5. How many domiciliary midwives are employed solely on postnatal visits to early discharge cases?

6. If you have vacancies for domiciliary midwives (shown in question 1) how long have they persisted?

3 months .....Yes/NoØ

6 months .....Yes/NoØ

12 months or more Yes/NoØ

For Official Use	A	B	C	D	E	F	G	H

7. How many midwives have left domiciliary midwifery in 1967? (if none, write none) .. ..

(number of instances)

What were the main reasons given:—

(*a*) Retirement .. ..

(*b*) Domestic, e.g. marriage, pregnancy, moving home .. ..

(*c*) Insufficient congenial work .. ..

(*d*) Other (known reasons) .. ..

.. ..

(*e*) Other (reasons not known) .. ..

(Total of (*a*) to (*e*) should equal the number who have left).

Deliveries

8. Number of confinements attended by domiciliary midwives during the period 1st January–30th September 1967 under N.H.S. arrangements .. .. (*a*) at home

(*b*) in hospitals*

(*c*) other

(*d*) total

Ø Delete as appropriate.

* Hospital includes consultant and G.P. beds.

9. How many domiciliary midwives have attended 5 or less deliveries during the period 1st January–30th September, 1967.

	If none, write none
(*a*) Part-time midwives shown in question 2 above	
(*b*) All others (including district nurse/midwives, etc.)	

Early Discharge Cases

10. How many women discharged from hospital received their first postnatal visit by domiciliary midwives during the three months July–September, 1967?

	No. of women	For official use
(*a*) discharged within 48 hours after delivery		
(*b*) „ 2–4 days „ „		
(*c*) „ 5–7 „ „ „		
(*d*) „ 8–10 „ „ „		
(*e*) „ 11 or more days „ „		
(*f*) Total		

11. Please estimate the number of women resident in your Authority's area who were delivered in hospitals* and other institutions during July–September, 1967 .. ..

Training in Domiciliary Midwifery

12. Is your Authority directly responsible for a complete Part II training of pupil midwives? .. .. Yes/NoØ

IF THE ANSWER TO 12 IS "YES" PLEASE ANSWER QUESTIONS 13-15

IF THE ANSWER TO 12 IS "NO" PLEASE ANSWER QUESTIONS 16-18

13. How many pupil midwife places per year (i.e. pupils per intake multiplied by number of intakes) do you provide? .. ..

14. Do you arrange practical training within your area for pupils from other areas? .. .. Yes/NoØ

15. Number of approved midwife teachers at 30th September, 1967 ..

16. Does your Authority accept Part II pupil midwives? .. .. Yes/NoØ

If "Yes":

(*a*) From a hospital Part II Training School in your area .. Yes/NoØ

(*b*) From a hospital situated in another LHA's area .. .. Yes/NoØ

17. How many pupil midwife places per year (i.e. pupils per intake multiplied by number of intakes) for pupils from

(*a*) a hospital Part II Training School in your area .. .. [ ]

(*b*) a hospital situated in another LHA area .. .. [ ]

18. Number of approved midwife teachers at 30th September, 1967.. [ ]

General Considerations

19. Has the deployment of domiciliary midwives been changed in any of the following ways:

(*a*) redundancy .. .. Yes/NoØ

(*b*) extension of home nursing duties of HN/DM .. .. Yes/NoØ

(*c*) alteration of range of duties.. .. .. Yes/NoØ

(*d*) other methods (describe) .. ..

..... Yes/NoØ

20. Are the changes in deployment the result of or associated with a higher institutional confinement rate .. .. Yes/NoØ

If "Yes", describe how.....

.....

.....

21. Are there any changes in the range of midwifery duties, *other* than increase in work with early discharge cases? .. .. .. Yes/NoØ

If "Yes", describe.....

.....

22. What do you consider to be the minimum number of deliveries per year a midwife must attend to retain her skills in delivery? [ ]

How do you arrive at this figure?.....

.....

.....

23. How many of your present domiciliary midwives other than those shown in question 5 would be prepared to undertake only post-natal care of mothers and babies (i.e., without attending delivery? .. .. [ ]

Future Administration

If you have views on the form of administration of midwifery services (for example, it has been suggested that they might be unified) the Sub-Committee would be pleased if you would indicate them here: if you would like to see changes, perhaps you would indicate the advantages, and disadvantages, of what you propose.

(Signed)

Medical Officer of Health.

Please return 2 copies of this questionnaire to: Ministry of Health,
Statistics and Research Division,
Room 414,
14, Russell Square,
London, W.C.1.

The third copy is for the use of the Authority. Further copies may be obtained from the above address, to which queries should also be referred (Telephone number: MUSeum 6811—Extension 269).

Ø Delete as appropriate.

* Hospital includes consultant and G.P. beds.

APPENDIX F

SUMMARY OF REPLIES TO QUESTIONNAIRE TO CHAIRMEN OF LOCAL MEDICAL COMMITTEES

FOREWORD

1. In March, 1968, a questionnaire was sent to the Chairmen of Local Medical Committees in England and Wales, asking them to express their views on the future pattern of the midwifery service as a whole, and setting down ten headings under which they might formulate their replies. The Chairmen were also asked to consider the possible role of General Practitioners in co-operative pilot schemes which might be set up in some areas.

2. The questionnaire was circulated to all 134 Local Medical Committee Chairmen, and 77 replies were received (a 58 per cent response). The aim of the following report is to set down the views expressed and to establish some consensus of opinion based on the doctors' replies.

3. It should be noted that some Chairmen expressed their personal views, some put the questionnaire before their Committee for discussion, in some cases a working group being set up for this purpose, while some handed the questionnaire to a doctor more involved than themselves in obstetrics and hence better qualified to make recommendations on this matter. The result is that all views expressed are of doctors either directly involved in, or particularly interested in, the Maternity Service.

I. THE CONTINUANCE OF DOMICILIARY MIDWIFERY

4. The majority view was that Domiciliary Midwifery should continue; 59 per cent voted in its favour, 26 per cent felt that it would have to continue, but should be discouraged; and 15 per cent felt that it should be discontinued.

5. The 59 per cent in favour emphasised the point that the patient must be allowed to decide whether or not she wishes to have her baby at home, although there should be certain conditions which must be satisfied before a doctor will agree to a home confinement; namely, that as a safety precaution, it be established that the patient's home is comfortable, clean and adequately equipped, and that, as far as is possible, it be established that no serious complication will arise in the course of the confinement. In this case, thorough antenatal care will be necessary, with specialist consultation at least in the early stages of the pregnancy and at 36 weeks. Some stressed that all doctors attending home confinements should be trained to the standard required for entry to the Obstetric List, and that the midwives accompanying them should be hospital based to ensure the maintenance of their skills. The doctor and midwife would then be able to deal with minor abnormalities. In cases of emergency, however, the patient should be taken by well equipped ambulance to a main hospital or, in rural districts, to a cottage hospital where there are facilities to deal with more serious abnormalities arising during the birth. It is appreciated that a home help service is at present provided, but some doctors suggested that it should be extended so that such facilities might be available for all patients having their babies at home. Some expressed the view that the present trend towards hospital confinement is largely the result of a misleading pressure on the public, encouraging them to believe that hospital confinement is always better. They felt that this was not necessarily true.

6. Various arguments were forwarded in favour of the continuance of domiciliary midwifery. It was felt above all that it is psychologically better for a woman to have her baby at home; the birth of a child is a family matter and should, if possible, take place in the shelter of the home. Again, if a woman already has young children, it is better for them that their mother is not taken from them for the period of confinement. Other points made in this connection were that a woman is running less risk of infection if she has her baby at home, that there is a financial saving if she does not make use of hospital facilities and that the pressure on hospital beds is lessened if the number of hospital confinements is reduced.

7. The 26 per cent expressing the view that domiciliary midwifery would have to continue, but should be discouraged, felt that patients who feel strongly that they would like to have their babies at home should be allowed to do so as long as the conditions stated in paragraph 5 above are satisfied. However, patients who have less positive feelings on this matter should be encouraged to go into hospital for at least the period of confinement, and criteria should be set down for compulsory admission to hospital; e.g. in the case of a patient with a past record of difficult births. The 24 or 48 hour hospital stay was highly recommended; this system would enable more patients to make use of hospital facilities, allowing them both the greater safety of a hospital confinement and the possibility of being back at home with their family very soon after the birth of the child. The extended use of the home help service was again mentioned in this context. On the whole, doctors sharing the view that domiciliary midwifery should be greatly reduced felt the service to be out-dated. They would prefer to see patients admitted for delivery to the maternity wing of a regional hospital, to a general practitioner maternity unit or to the delivery wing of a cottage hospital. In this case, all midwives would be in some way hospital based. either spending part of the year working in hospital and part in the district, or visiting patients at their homes for antenatal and postnatal care and following them into hospital for delivery.

8. 15 per cent were against the continuance of domiciliary confinements. They felt it to be grossly out-dated and far too risky, pointing out that as the number of domiciliary cases declines, general practitioners and district midwives lose their expertise. Such a situation, they said, would be avoided if separate domiciliary midwifery was discontinued and hospital midwifery facilities were expanded to cope with the increased burden. A 24 or 48 hour hospital stay system was favoured by most of the doctors holding this point of view, as was the principle of the general practitioner attending his patients at hospital confinements so that an element of continuity and of personal care its maintained in the service.

9. The majority view was, therefore, that domiciliary midwifery should continue. Most favoured the increased use of the minimum hospital stay system, either for patients who would prefer hospital confinement or for all maternity patients, and in the latter case domiciliary service would tend to develop into a service for domiciliary antenatal and postnatal care, the midwife working both in the district and in a hospital to maintain her professional skills. Some doctors felt that all the midwifery services should be either hospital or clinic based and thus the midwife engaged solely in domiciliary work should be abolished. There was, therefore, on the one hand the demand for integration of the maternity services, and on the other hand the demand for an increase in hospital maternity facilities to precede the total hospitalisation of the service.

II. ARRANGEMENTS FOR GENERAL PRACTITIONERS TO PROVIDE MATERNITY MEDICAL SERVICES TO THEIR PATIENTS IN HOSPITAL

10. Doctors agreed overwhelmingly that general practitioners should be able to provide maternity services to their patients in hospitals or maternity units. Only one of the 77 replies expressed any doubt, saying in this case that although it may be desirable for general practitioners to provide such a service, there are insuperable administrative

problems, for in large towns many general practitioners will have access to a relatively small number of hospital beds. Some of the doctors expressing their views raised a second problem, namely that if a general practitioner were to take part in a hospital maternity scheme, he would have to cope with an increased work load and oragnisational difficulties. If the doctor is to follow his patient into hospital for her confinement he will probably be faced with clashes in his time-table and, above all, more irregular working hours. However, such problems were not felt to be insuperable, particularly for doctors working in group practice.

11. In favour of the principle of general practitioners providing maternity medical services in hospitals, it was suggested that it is highly preferable for a maternity patient to be treated in hospital by her own general practitioner whom she knows and in whom she has confidence. The general practitioner is the natural person to deal with such a matter, and he would act as a channel of communication between patient and hospital staff, thus helping to overcome the patient's apprehension and to make easier the work of the hospital staff. The aim would be to secure continuity of treatment, the general practitioner seeing his patient at antenatal and postnatal sessions and attending her hospital confinement, in normal cases, to ensure the patient's ease, and to bring about a reduction in the consultant's workload so that he may attend to the more problematic cases which are in greater need of his expert care.

12. On the point of organisation, many suggested that the general practitioner should be integrated into the hospital maternity service to deal, however, only with normal cases and working on the understanding that if any difficulties should arise the consultant obstetrician must be called in; formal limits for general practitioner care might be set down to facilitate this. The implication was that most doctors favoured the idea that general practitioner beds be accommodated in special general practitioner units which would be separate from, though within easy reach of, a consultant unit. 14 per cent categorically expressed such a preference, 41 per cent implied that this would be their choice, 33 per cent made no reference to the nature or situation of general practitioner beds. 12 per cent, however, specifically recommended that the general practitioner beds should be in the consultant unit, a general practitioner working as a member of the hospital obstetric team with the midwives and with the consultant who would have the overall responsibility for the unit. The general practitioner might then gain a wide range of experience, eventually being able to cope with some of the complications arising and lessening the consultant's workload.

13. However, most visualised the general practitioner working in a totally separate unit, and in this case he would have overall responsibility for his patients. He would hold antenatal and postnatal sessions at a hospital, at a unit or at his surgery, attending confinements and transferring all difficult cases to the consultant unit, whereupon the consultant would assume responsibility. General Practitioner units might be staffed either by a permanent team of midwives, or by a team of hospital midwives and the domiciliary midwives attached to the doctors using the unit. It was generally felt, that the doctors should satisfy certain criteria to qualify for the use of hospital maternity beds, either as for the Obstetric List or as decided by the individual hospital authority. There should be a clearly defined on-call rota, or each doctor should make sure that he will be able to attend his patient at her confinement. Emphasis was placed on the view that general practitioners should be of real status in the unit, and should be remunerated adequately, perhaps on a sessional basis. It was felt that if the unit is well enough equipped general practitioner obstetricians will be able to cope with minor abnormalities, thus relieving the consultant's burden, and if a short-stay system is introduced, hospital facilities will be available for a greater number of maternity cases than at present.

14. The majority opinion favoured arrangements for general practitioners to provide maternity medical services to their patients in hospitals, and preferably in separate

general practitioner units. Such an arrangement, it was felt, would be feasible for a doctor in group practice who might be sufficiently involved in midwifery to make it worthwhile gearing his practice to obstetrics. The single-handed doctor and doctors in designated areas, however, would probably have to face organisational difficulties. The main point in favour of a general practitioner obstetrician having hospital maternity beds was that a continuity of treatment and a warm and relaxed atmosphere, such as is often lost in the present consultant maternity unit, would be maintained in the service. Or again, that the opportunity of such hospital work would attract doctors into general practice. The important proviso made throughout was that the general practitioner obstetrician must maintain a constantly high level of efficiency if he is to earn the respect and trust which is essential to his being accepted as an equal by the hospital staff and to the smooth working of the whole machine.

III. ATTACHMENT SCHEMES WITH DOMICILIARY MIDWIVES, AND THE EMPLOYMENT OF DOMICILIARY MIDWIVES IN HOSPITAL

15. The vast majority (97 per cent), was in favour of both attachment schemes and the employment of domiciliary midwives in hospital. Both were seen as steps towards the overall aim of greater continuity within the service.

16. It was felt that domiciliary midwives might be usefully attached to doctors in general practice, working with several practices of single-handed doctors or with just one group practice. Such a scheme would in the first place secure a greater element of organisation in this area of the service, with practitioner and midwife working together as a team, so providing a superior service and saving time through co-ordination. The domiciliary midwife, in this case, would continue in her present role, visiting her patients at home throughout and after pregnancy, but in addition she would attend general practitioner antenatal and postnatal sessions, also home confinements with the general practitioner as a member of a team.

17. Many based their replies on the assumption that general practitioners, in a reorganised service, would provide maternity medical services to their patients in practitioner hospital beds, and thus felt that the domiciliary midwife should be employed in hospital to work hand in hand with the general practitioner, attending with him any remaining home confinements, antenatal and postnatal sessions at a clinic or maternity unit, and caring for patients during a short hospital confinement, (24 or 48 hour stay), after which the patient would return home to continue under the midwife's care. It would be essential for the smooth running of such a system that all domiciliary midwives working in hospital should enjoy the same status as their fellow midwives employed permanently there. This, it seems, has proved a problem for those already involved in such a scheme: relations between domiciliary and hospital midwives have become so unsatisfactory that the situation has become quite untenable.

18. In this connection, a large number, (45 per cent), while agreeing that the present situation is probably best met by measures as suggested above, felt that the role of the domiciliary midwife might, in a reorganised service, be abandoned, and that all midwives might be hospital based. The system would then be that some hospital midwives would be attached to a general practitioner providing maternity medical services in that hospital, working with him in the hospital, attending general practitioner clinics and coping with any remaining domiciliary work: or, that midwives would spend some time working in hospital and some in the district, thus following a system of rotation. In both cases the midwife is better equipped to cope with the ever decreasing number of home confinements she has to attend, her skills being better maintained than the present system in most cases allows. A more even distribution of midwives would be attained, correcting the present imbalance whereby there are over-worked hospital midwives and underworked domiciliary midwives, and any conflict between hospital and domiciliary midwives would be avoided. Those who considered that all confinements should take

place in hospital felt that the aspects of district work which do not call for midwifery skills should be carried out by other workers. The domiciliary midwife concerned only with domiciliary work would no longer exist, and all midwives would come under one authority, probably that of the Regional Hospital Board—not that of the Local Health Authority.

19. The views expressed in favour of attachment schemes and the employment of domiciliary midwives in hospitals varied in intensity, but all seemed to feel that changes along these lines would make for an improved service. There would be a continuity of care such as is not generally found under the present system: this would be psychologically better for the patient, and would avoid duplication of service and clashes in terms of clinical advice.

20. However, mention should be made of the disadvantages, stated by the few, of such schemes. In connection with attachment schemes, it was felt that there might be geographical problems, but organisational and personal problems were foreseen in connection with the employment of midwives in hospital. Domiciliary midwives work to a formal on and off duty system, but if they were to give continuous care to general practitioner patients their hours would be irregular and doubtless many domiciliary midwives who have families of their own would be discouraged from the service. The remedy here would be the use of an on-call rota, in which case the aim of continuity would be forfeited.

IV. RELATIONSHIP BETWEEN GENERAL PRACTITIONER OBSTETRICIAN AND CONSULTANT OBSTETRICIAN, INCLUDING LIAISON ARRANGEMENTS

21. It was unanimously agreed that a good relationship should be established between the general practitioner obstetrician and the consultant obstetrician, basically fostered through mutual respect and trust. Some felt that this develops naturally, particularly when the general practitioner and the consultant have joint hospital use. This matter will depend upon their personalities, and it was mentioned that cases have arisen in which the consultant was not always willing to co-operate with the general practitioner who provides maternity medical services in hospital.

22. However, some felt it to be possible that this relationship might be fostered through formal liaison. Local Medical Committees might take on this function, or a satisfactory situation might be achieved by setting up obstetric liaison committees made up of the general practitioners, the consultant, the medical officer of health and the midwives working together. In the first place the committee should meet to discuss the setting up of any new obstetrics scheme, whether this be for the general practitioner to provide maternity medical services in beds allotted to him from the consultant unit, or for him to provide a similar service in his own hospital unit. There might then be periodic meetings to discuss difficulties. Another suggestion was that regular seminars might be held for those involved in hospital obstetrics: through these the general practitioner and the consultant might establish common ground which would be the basis of a sound relationship.

23. On the point of formal organisation, doctors' comments varied according to the type of service they visualised for the future. In the case of general practitioners providing a domiciliary obstetric service it was felt that the consultant obstetrician should see the patient in the early stages of pregnancy, and at 36 weeks. The patient might attend the consultant's clinic, or the consultant might see the patient under some domiciliary visiting scheme. A general practitioner working in a separate general practitioners' unit would have overall responsibility for his patients, but they would see the consultant at least twice during the course of pregnancy to ensure that abnormalities in delivery were unlikely and that the general practitioner would be well able to conduct the confinement. The general practitioner would hand all difficult cases to the consultant obstetrician and the patient would then become the consultant's responsibility. The

consultant would have overall responsibility for patients using general practitioner beds within his own unit, and in this case the general practitioner would work as a member of the hospital obstetric team, and would enjoy the status of a respected member of that team.

24. Hence, opinion was in favour of a close relationship between the general practitioner obstetrician and the consultant obstetrician, and largely it was implied that the nature of this relationship and the means chosen to achieve it should be decided by the people involved: no hard rules could be set down, but the means should be suited to the individual situation and the individual personality. The possibility of a division of overall responsibility between consultants and general practitioner obstetricians in a combined maternity unit was not mentioned.

V. THE ADMINISTRATION OF MATERNITY DEPARTMENTS ADMITTING PATIENTS UNDER THE CARE OF THEIR GENERAL PRACTITIONERS—BOOKING POLICY, ON-CALL ROTA, EMERGENCY PROCEDURES, EQUIPMENT ETC.

25. The most important point made in connection with the administration of such maternity departments was that all arrangements should be designed to suit local conditions—any general plan would be impractical. However, doctors made many helpful suggestions under this heading.

26. It was felt that if a general practitioner obstetric unit is in operation it must be seen, (a) as an integral part of general practice, and (b) be fully staffed with a sister, nurses, permanent midwives and attached midwives. The administration of such a unit might be decided by a fully representative committee, including nursing staff. Alternatively, this might be left in the hands of the general practitioners and the consultant, a medical advisory committee with general practitioner representation or of an obstetric liaison committee. Several doctors stated that the Central Midwives Board's concern with the training of midwives should not influence the administration of schemes of this kind.

27. A few doctors suggested that, according to the facilities available, each participating general practitioner obstetrician should be allowed a certain number of deliveries for which he would be responsible unless, in case of emergency, the patient was handed into the specialist's care. The number of beds allotted to any one general practitioner, whether in a separate unit or in the consultant unit, might be related to the number of patients on his list who are of child-bearing age.

28. Booking was thought best organised according to local conditions, giving priority not only to abnormal cases, but also to cases in which there is social difficulty. The domiciliary midwife would inspect home conditions and decide whether or not admission on social grounds is desirable. The general practitioner might deal with bookings for his own maternity beds, taking applications from his patients or alternatively, this might be left to the hospital maternity departments who would notify the general practitioner as soon as his patient's booking was confirmed.

29. Most felt that an on-call rota for general practitioner obstetricians should be drawn up by mutual agreement, as at present in group practices, and there should also be an arrangement by which the consultant may be called in emergency cases. An alternative suggestion, however, was that there should be no on-call rota, but that the general practitioner should be called when his patient is in labour—if he cannot attend, the hospital would take full responsibility. Above all good communications and organisation would be essential.

30. It was unanimously stated that general practitioner units should be as fully equipped as possible in each case, and should be within easy reach of a specialist unit to which serious cases might be transferred. The equipment, to be provided by the hospital, would include at least, for example, general anaesthetic apparatus and infant resuscitation equipment: equipment should be adequate for all but theatre work.

VI. THE ROLE OF GENERAL PRACTITIONER CLINICAL ASSISTANTS

31. Clinical assistantships were seen largely as the means by which general practitioners might gain obstetric experience in preparation for work in a general practitioner obstetric unit, or as a form of refresher course for doctors still operating a domiciliary maternity service. The former might be long term appointments of say 1 or 2 years, with general practitioners working under the consultant obstetrician and so learning to deal with minor abnormalities arising during confinement. The latter would be short term appointments, perhaps in the form of relief for the house surgeon. Alternatively, clinical assistants might work largely in antenatal clinics. Two doctors thought that general practitioners providing maternity medical services in hospital should be clinical assistants, their status never rising above this.

32. Such clinical assistantships were thought valuable in that they might be educational appointments, but they would have a two way benefit. Assistants would lessen the work load of the permanent hospital staff, though they should never be used to cover hospital staffing deficiencies. They might, according to the system under which they were appointed, act as a liaison between consultant and general practitioner units and might keep consultants in touch with the problems of general practice.

33. It was thought essential that the post of clinical assistant should be formally appointed and that their work and ability should be adequately remunerated: also that the clinical assistants' legal position should be clearly defined so as to avoid any problems arising out of split responsibility.

34. All the doctors expressing their views for this report felt general practitioner clinical assistantships to be valuable and desirable. However, present conditions in general practice make it difficult for doctors to take such appointments, so that at the moment schemes under which general practitioner obstetricians may use hospital maternity beds were seen as a more realistic proposition.

VII. THE OBSTETRIC LIST

35. Most doctors, (95 per cent), commented upon the obstetric list, but they were very divided in their opinions.

36. The largest group, (45 per cent), while agreeing that some sort of obstetric list is necessary, thought that the criteria for admission should be amended. Criteria might be set down in each area or there might be a national policy on this matter: these views were equally favoured, but in all cases emphasis should be placed on making the obstetric list a true reflexion of a doctor's current ability—it could be stated that doctors must complete a certain minimum number of maternity cases per annum if they are to qualify for, or remain on, the list, also that they must attend regular postgraduate courses at prescribed intervals. Other suggestions were that all general practitioners qualifying in the first place for admission should hold the D.R.C.O.G. or should have had some practical hospital experience in obstetrics. In a co-ordinated service the list should be restricted to those willing to satisfy criteria in antenatal care, attendance at delivery, adequate postnatal care and general practitioner obstetrician refresher courses.

37. 26 per cent were quite satisfied with the present system and would wish it to continue as a means by which doctors skilled in obstetrics may be identified as such.

38. 24 per cent, however, felt the obstetric list to be an outdated formality. They thought a good reputation the best indication of a doctor's skills in obstetrics and that all general practitioners trained in obstetrics should be capable of giving maternity services as they are capable of giving other services.

39. It was accepted, therefore, by 71 per cent that there must be some way in which a general practitioner obstetrician may be identified as such, and this becomes more

essential as the number of home confinements falls, for one must be able to recognise a doctor who has maintained his skills. Finally, it was hoped that in a unified service it will be possible for one of a group of doctors to take on all the obstetric work, devoting a considerable amount of time to this and maintaining his skills at the highest possible level.

VIII. TRAINING AND MAINTENANCE OF SKILLS

40. Everyone stressed the importance of this matter. It is obviously essential that general practitioners providing maternity medical services for their patients in hospital beds should be well trained and should maintain their skills, but this is equally important for general practitioners providing an obstetric service within the normal course of his practice—for it is his task to spot any abnormal pregnancies at any early stage so that these may be dealt with as soon as possible.

41. Repeatedly doctors, in expressing their views upon this matter, referred to the report, Obstetrics in General Practice, issued by the Royal College of Practitioners in May, 1968. Since all the views expressed are embraced by the Report, it is necessary to do no more than refer to paragraphs 64 to 83 (inclusive) of the above mentioned document.

IX. SPECIAL PROBLEMS IN RURAL AREAS—PATIENT TRANSPORT PROBLEMS IN GENERAL

42. Many doctors felt themselves unqualified to make comments under this heading. 45 per cent, however, made valuable suggestions. Perhaps the most outstanding point made was that in rural areas antenatal care must be of a particularly high standard to ensure, as far as is possible, that all abnormal cases are admitted to hospital well before the period of confinement, the aim being to avoid domiciliary emergency, or grave emergency in small local hospital units where staff and equipment are inadequate to cope with the situation. It was felt, further, that patients from rural areas should be given priority in the use of hospital beds. Any trend towards total centralization is dangerous in that rural patients' access to hospital facilities becomes more and more remote.

43. Suggested immediate measures to lessen problems experienced in rural areas included a prompt ambulance service, well equipped ambulances in which the doctor and midwife could accompany the patient to hospital, flying squads and the provision of transport for patients to attend clinics.

44. Another idea was that domiciliary cases in each rural area might be dealt with by a special general practitioner employed for a limited time, perhaps immediately after he has attended a postgraduate course in obstetrics. This system would provide a good training ground for doctors wishing to work in obstetrics, and supplementary payment might act as an inducement. An important point was that there will be problems in rural areas until organised locum schemes are in operation. A general practitioner cannot satisfactorily maintain his skills in obstetrics if he is unable to attend refresher courses, and it is vital for a safe and well run service that the members of the obstetric team have thorough and current experience.

X. PLACE OF THE GENERAL PRACTITIONER OBSTETRICIAN IN A UNIFIED MATERNITY SERVICE

45. Some doctors made the point that discussion about the future of the Midwifery Service cannot exist in isolation. These changes must be seen in the context of the overall changes which are to be made in administration of the National Health Service.

46. However, for opinions upon the place of the general practitioner obstetrician in a unified service, reference should be made to the comments under headings I–VIII as set out above. Repetition would be pointless, but, in brief, it was agreed that the general

practitioner would play an important part in any unified maternity service. He would liaise between hospital and midwife, and hospital and patient, he would provide an invaluable personal service and would play a part in lessening manpower problems. Some saw the general practitioner working in a general practitioner maternity unit in which he would have total responsibility, others saw him working as a team member in a specialist maternity unit: or again, he might, within the hospital, be restricted to antenatal and postnatal clinic work.

XI. PILOT SCHEMES

47. Very little attention was given to the matter of pilot schemes. It was simply expressed that if a unified service is to be considered, such schemes will be essential in varying types of areas.

XII. GENERAL REMARKS

48. The problem to be faced in this Report is that many of the views expressed are ideals rather than practical suggestions; there is much conflict between what is desirable and what is organisationally possible. There would be, for instance, great administrative problems if, as was suggested, midwives were both hospital based and attached to doctors in general practice. Also, it would be difficult to achieve both the aim of only well qualified general practitioners working in obstetrics, and the aim of continuity of care within the maternity service. Inevitably, some general practitioners will not be highly skilled in obstetrics, either because they prefer to devote themselves to other aspects of their work or because they are unable to find time to gain the necessary experience or to attend the necessary training courses.

49. As some doctors suggested, the concept of the general practitioner providing maternity medical services to his patients in hospital or on a highly organised scale in the patient's home, is really only tenable if doctors are working in group practices. This would introduce a note of specialisation into general practice, one doctor devoting much of his time to the maternity patients of the whole group of which he would form a part. He would attend them from the early stages of pregnancy, would conduct the confinement in normal cases and would supervise postnatal care, thus achieving a continuity within the service without involving himself in administrative and organisational problems.

XIII. STATISTICAL SUMMARY

Questionnaires circulated—134.

Replies received by 30th October—77.

I. **The Continuance of Domiciliary Midwifery.** 59 per cent in favour. 26 per cent felt that it must continue but should be discouraged. 15 per cent totally against.

II. **Arrangements for General Practitioners to Provide Maternity Medical Services to Their Patients in Hospital.** 99 per cent in favour, 1 per cent against. The ideal upheld, but practical problems.

III. **Attachment Schemes with Domiciliary Midwives, and the Employment of Domiciliary Midwives in Hospital.** 97 per cent in favour. 45 per cent in favour of all domiciliary midwives being hospital based. Organisational problems.

VII. **The Obstetric List.** 95 per cent dealt with this: 24 per cent felt it to be outdated; 45 per cent in favour, but felt the criteria for admission should be reviewed; 26 per cent satisfied with the present system.

APPENDIX G

QUESTIONNAIRE TO SENIOR ADMINISTRATIVE MEDICAL OFFICERS OF REGIONAL HOSPITAL BOARDS

CENTRAL HEALTH SERVICES COUNCIL

STANDING MATERNITY AND MIDWIFERY ADVISORY COMMITTEE

SUB-COMMITTEE TO CONSIDER THE FUTURE OF THE DOMICILIARY MIDWIFERY SERVICE

.....Region

1. Number of General Practitioner beds available for maternity cases:

(*a*) in same ward as Consultant beds	
(*b*) in hospital and close to Consultant ward	
(*c*) within hospital curtilage but separated from Consultant Ward	
(*d*) in completely separate (G.P.) unit	
(*e*) Total	

2. List of areas or H.M.C.'s where requests for hospital maternity beds are not satisfied. Please tick columns 2 or 3 to show grounds on which additional beds would be needed to meet all requests in the area and columns 4 to 7 to show facilities which would be insufficient for this purpose. If there are no such areas please enter NIL.

Area (or H.M.C.)	Additional beds would be needed		Facilities which would be insufficient			
	To meet requests of priority groups	To meet other requests	Ante-natal beds	Delivery suite beds	Lying-in beds	Other facilities
(1)	(2)	(3)	(4)	(5)	(6)	(7)

(*a*) Have you experienced difficulty in staffing existing maternity beds ? Yes/No

(*b*) If Yes, please state reasons.

4. **Catchment areas.**

(*a*) How many maternity hospitals* have definite catchment areas .. ..

(*b*) Would it be feasible to define catchment areas for the remaining hospitals? Yes/No

5. **Obstetric flying squads.**

(*a*) Number of flying squads based in the region. (Please complete a separate appendix A for each flying squad) ..

(*b*) On the basis of your experience what do you consider should be the medical and nursing staff for a flying squad?

(*c*) General comments (e.g. difficulties of maintaining the service).

6. **Hospital midwifery districts.**

Please state which hospitals* provide a domiciliary midwifery service, and the number of separate domiciliary staff (whole-time equivalent) they employ.

7. **Local authority domiciliary midwives working in hospitals.**

(*a*) In how many hospitals* do domiciliary midwives undertake deliveries .. ..

(*b*) How many domiciliary midwives (whole-time equivalent) are involved? .. ..

(*c*) How many cases were delivered in hospital by domiciliary midwives during 1967 (if known)? .. ..

(*d*) How many included in (b) are doing work which could otherwise be done by hospital midwives on the establishment? .. ..

(*e*) How many included in (b) are necessarily helping to staff hospitals? .. ..

(*f*) Names and addresses of hospitals included in (a):

8. How many hospital midwivesØ (excluding administrative and supervisory staff) are employed solely† on the following:

		W.T. Staff	P.T. Staff
†(does not include rotating duties)	(*a*) Antenatal		
	(*b*) Delivery		
	(*c*) Postnatal		
	(*d*) Special care baby units		
	(*e*) Milk kitchens		

Ø excluding pupil midwives.

* includes hospitals with either consultant or G.P. maternity beds.

9. Is there a trend towards specialization within midwifery. If so, please specify (e.g Antenatal, delivery suite work) indicating in which hospitals* particular trends are evident:

10. Has the pattern of work of hospital midwivesØ changed?:

(*a*) as the result of the increase in the number of hospital confinements .. .. Yes/No

(*b*) for other reasons (please specify):

11. **Vacancies for Hospital midwivesØ** (all grades).

(*a*) Numbers of vacancies (whole-time equivalent) at 31st March, 1968 .. .. | |

(*b*) Number of hospitals which had vacancies at 31st March, 1968 which had persisted for:

(i) under 3 months	
(ii) 3 months and under 6 months	
(iii) 6 months and under 12 months	
(iv) 12 months or more	
(v) Total number of hospitals with vacancies	

12. How many midwivesØ are known to have left hospital midwifery during 1967 .. .. | |

Ø excluding pupil midwives.
* includes hospitals with either consultant or G.P. maternity beds.

13. **What were the main reasons given for leaving:**

(*a*) Retirement	
(*b*) Domestic, e.g. marriage, pregnancy, moving home ..	
(*c*) Insufficient congenial work	
(*d*) Other reasons	
(*e*) Reason not known	
(*f*) Total (as at item 12, above)	

14. **Training of Midwives.**

Please state the number of midwifery training schools in the Region:

(*a*) Part I	
(*b*) Part II	
(*c*) Combined	

15. (*a*) How many pupil midwife places did they provide in 1967

	Part I	Part II
Number of Places ..		
Number of Intakes ..		

(*b*) What was the total number of pupil midwives accepted for training in 1967

(*a*) Part I	
(*b*) Part II	

16. (*a*) Has the setting up of additional midwifery training facilities (Part I and/or Part II) in the Region been contemplated in the past 2 years? .. .. Yes/No

(*b*) If Yes, with what objectives? .. ..

17. (*a*) Have formal steps to achieve this been taken .. .. Yes/No

(*b*) If Yes, have the objectives stated in answer to 3(b) been achieved?

(*c*) If they have not, please indicate for what reasons.

18. **Supervision of midwives.**

To what extent does the supervision provided under Section 31 of the Midwives Act, 1951 (read with earlier Acts, including Section 8 of the Midwives Act, 1902) afford assistance to hospitals as employers of midwives (please comment).

19. **Early discharge.**

(*a*) Does planned early discharge under the present arrangements lead to any administrative difficulties (Please state).

(*b*) What is the reaction of hospital midwives to 48 hour discharge

20. **Maternity Liaison Committee.**

(*a*) How many exist in your region?	
(*b*) How often do they meet?	
(*c*) How effective are they?	

21. **S.A.M.O.'s views on the future pattern of services and administration.**

In putting forward suggestions on the possible future pattern of maternity services it would be helpful if some estimate could be given of the number of hospital midwives likely to be needed, and some comments made on arrangements for their training appropriate to the pattern of service which you envisage.

APPENDIX A

Please complete one form for each obstetric flying squad.

1. Name and address of hospital where flying squad is based:

2. What is the estimated average duration and distance of journeys in answer to calls (i.e. outward journey only), and the maximum range of such journeys:

   (*a*) average.....miles.....minutes.

   (*b*) maximum.....miles.....minutes.

3. Which of the following actually went on the last visit (please tick as appropriate):

Consultant	
Registrar	
House Officer	
Anaesthetist	
Midwife or Nurse	
Medical Student	

4. What transport was used for the last visit

5. Total number of calls answered during 1967, and details (if known)‡.

	Domiciliary	G.P. Unit	Other	Total
(*a*) Abortion				
(*b*) Antenatal complications				
(*c*) Delivery				
(*d*) Postnatal complications				
(*e*) Total				

‡ Please give grand total in any case, and complete the table as far as possible from such information as is readily available.

APPENDIX H

MATTERS ON WHICH THE VIEWS OF THE CENTRAL MIDWIVES BOARD WERE SOUGHT

1. The possibility of integration of the present hospital and local authority maternity services under the administration of hospital authorities or, if and when these emerge, area health boards.

2. In the event of such integration, the provision of domiciliary midwifery to be undertaken by hospital-based midwives, possibly under a system of rotation.

3. The encouragement of combined general practitioner/consultant obstetric units to permit common use of maternity beds, delivery suites and other hospital facilities. (The possible effects of such combination on the arrangements for training midwives is a matter of particular interest to the Sub-Committee).

4. The means by which standards of professional skills might be maintained if midwives were allowed to continue to conduct confinements solely in the domiciliary field, having regard to the falling domiciliary confinement rate.

5. The form of supervision of midwifery which would be appropriate to an integrated service.

6. The possibility that intending midwives who wished to undertake work other than the conduct of confinements might be enabled to specialise at some point during their training.

7. Under the present tripartite system, so long as it prevails, the encouragement of closer co-operation between hospitals and local authorities, with local authority midwives freely available to work in hospitals where this would be mutually advantageous.

CENTRAL MIDWIVES BOARD

Memorandum of Evidence to the Sub-Committee on the Future of Domiciliary Midwifery and Bed Needs

1. The Board fully agree that there should be integration of the present hospital and domiciliary midwifery services.

In many areas considerable adjustment of organisation and staffing would have to be made to the hospital authorities as at present constituted to enable them to undertake the administration of an integrated service.

2. In areas where integration is possible, the domiciliary service could be administered from the hospital. Where midwives are employed full-time in urban areas some rotation of duties may be possible although not all midwives will wish to take part in this. In the Board's view difficulties in areas where there are a number of district nurse midwives are likely to be insuperable.

The Board do not think that 100 per cent hospital delivery over the country as a whole will ever be achieved and are satisfied that in all areas there will be a continuing need for midwives to be available for domiciliary deliveries. The proportion will vary from area to area. 184,000 women were delivered in their own homes in 1967 and the domiciliary midwifery service also undertook the postnatal care of over half the hospital deliveries (314,000 early discharges in 1967).

The Board are of the opinion also that with the increasing attachment of midwives to group general medical practice and the continued use of general practitioner obstetric units the overall standard of midwifery will be better and the administration will be simpler and more efficient if certain midwives are geared to the general practitioner service rather than to the hospital service.

3. The Board allow the use of general practitioner beds in the training of Part II pupils, but they have not yet been accepted for Part I midwifery training. With the introduction of integrated training and with closer integration of general practitioner beds into consultant units this difference may disappear, and indeed the Board would welcome suitable general practitioner obstetrician participation in midwifery training, subject to detailed approval and control by the Board.

4. The present statutory provisions for the Board to make rules about refresher courses (Midwives Act 1951 Section 4(i)(d)) would enable suitable courses to be devised and made compulsory.

5. The Board have urged a revision of the statutory provisions for local supervision of midwives (Midwives Act 1951 Section 17(1)). In the Board's view supervision (involving as it does midwives practising in nursing homes, religious organisations, prisons, the defence services and private domiciliary practice, as well as the national health service) should be separated from provision of the service. Indeed the failure of some local health authorities to undertake supervision, as distinct from organising their own domiciliary service, has been a source of weakness for some time.

6. In the Board's view a midwife needs to understand the total care of the patient in order to be able to carry out any part of that care and the Board have no intention of introducing a second grade of midwife which would in any case be outside the terms of the present Midwives Act.

7. Co-ordination is already taking place in many areas where domiciliary midwives are available and are willing to work in hospitals under the terms of the Health Services and Public Health Act, 1968.

The Board suggest the following interim measures:

(*a*) the appointment of hospital obstetric and paediatric consultants to local health authority staffs with advisory responsibilities for a defined area;

(*b*) the appointment of local authority supervisors of midwives to hospital staffs with liaision responsibilities for a defined area;

(*c*) the definition of the function of the health centre or group practice to supplement or replace local authority and hospital clinics in the maternity service;

(*d*) the areas of responsibility of hospital for maternity care should be reviewed and redefined.

6th March, 1969.

APPENDIX I

FACTORS AFFECTING THE NEEDS FOR MATERNITY BEDS

1. The main factors which have been considered as influencing maternity bed needs are the number of live and still births, the percentage of these born in N.H.S. hospitals, the postnatal length of stay, the percentage occupancy and the percentage of beds used for antenatal care.

2. Past trends in these factors are presented graphically as a help towards judging the values which the factors might take at future dates, but projections of births are given to 1981.

3. A table of bed needs is given for the period 1969–1981 based on the birth projections and using different assumptions about the values of the other principal factors. This table can be used in two ways—either as a guide to the number of beds needed to achieve a given percentage (80, 90, 100) of births in N.H.S. hospitals or, given the number of beds likely to be provided at future dates, to estimate the proportion of births which can take place in hospital on various assumptions about postnatal length of stay, bed occupancy and the proportion of beds that may be required for antenatal care.

4. Graph I shows the number of live and still births from 1953 to 1968, with estimated numbers for 1969 to 1981, based on the mid-1968 Government Actuary projections of live births, with a small correction to include still births. Births reached a maximum of nearly 900,000 in 1964, but have since decreased. Future estimates indicate that, by 1972, the number will have reached the 1964 peak and will continue to increase, but at a slower rate after 1973. The total number of births (domiciliary and hospital) per available bed is shown as an indication of the pressure on the hospital maternity services, and has been decreasing since 1964.

5. Pressure on the inpatient maternity services appears to be closely correlated with throughput—the higher the pressure, the higher the throughout—as is shown in a regional comparison in Table 4. If future provision of maternity beds rises at about the same percentage rate as births (for example, from about 23,000 beds in 1969 to about 25,000 in 1981) then pressure on the hospitals will remain static at the rather low 1968 level and a special stimulus may be needed if the proportion of births in hospital is to continue to rise as it has done recently.

6. Graph II shows that the percentage of births taking place in N.H.S. hospitals has increased rapidly since 1960 to nearly 80 per cent in 1968. (A small percentage, about 3 per cent, of births take place in private nursing homes). The main change in length of stay has been in the postnatal stay (Graph III) which declined from about 11 days in 1955 to under 7 days in 1968, whereas the antenatal stay has remained at about 4 days. Bed occupancy (Graph II) which in 1957 and 1963 exceeded 82 per cent was at 74 per cent in 1968. The decline in occupancy since 1963 seems to be associated mainly with the decline in the birth rate. Graph IV shows that the drop in percentage bed occupancy since 1964 has occurred in both consultant obstetric and g.p. maternity units, but that g.p. maternity units always have a lower per cent occupancy than consultant obstetric presumably associated with the small size of the g.p. units. The marked increase in the proportion of g.p. maternity units is shown and if this increase continues, overall bed occupancy may tend to be depressed. A lower postnatal stay will also tend to lower bed occupancy since the interval between occupation remains static (at about 2 days) and the higher number of spells of bed occupation in, say, a year will require a higher proportion of the year for turnround of beds.

7. Graph III shows the increase in the proportion of beds used for antenatal care, which may be a spell of care alone or the period prior to delivery. This is mainly a reflection of the fall in postnatal compared with the comparative stability of antenatal stay. The *numbers* receiving antenatal inpatient care has risen at about the same rate as the numbers receiving postnatal care (by 44 per cent compared with 42 per cent, between 1958 and 1966).

8. The actual numbers of beds allocated, available and occupied daily is shown in Graph V for 1953 to 1968. The slight difference between allocated and available beds (2 per cent) is due to beds *temporarily* out of use for redecoration, staff shortages etc. The actual number of beds occupied has remained fairly constant since 1964.

9. Table 5 is the main table of bed needs. The estimates of the average number of beds available daily are based on the projections of births in Table 2 and on the following ranges of values:

(*a*) per cent of births in hospital: 80, 90, 100;

(*b*) postnatal length of stay: 7, 6, 5 days;

(*c*) per cent occupancy: 75, 65;

(*d*) per cent beds occupied for antenatal care: 30, 25.

No correction has been made for multiple births in order to leave a margin for transferred cases, and readmissions, especially important with regard to the trend towards earlier discharge. The full range of values is given in each table, although some combinations of figures are unlikely, i.e. 100 per cent hospital births in 1969. The situation in 1968 is shown in Table 1, when the proportion of beds used for antenatal care was probably about 27·5 per cent. It may be advisable to think in terms of a proportion of 30 per cent in, say, 1981, and a bed occupancy of not more than 80 per cent.

10. As an example of the use of Table 5, a postnatal stay of 6 days in 1981, with 30 per cent of beds allowed for antenatal care, an occupancy of 75 per cent, and a proportion of births in hospital of 90 per cent, would require about 26,000 beds available daily, compared with a provision of about 24,000 beds available daily in 1969. Further values may be obtained by interpolation, and using the basic data from the previous example, but increasing bed occupancy to 80 per cent would give an estimate of 24,500 beds in 1981 compared with 22,500 in 1969.

11. Table 3 shows the percentage distribution of maternity cases by the number of days' stay after delivery for the half years from 1964 to the first half of 1968. These distributions correspond to postnatal stays of about $6\frac{1}{2}$–$7\frac{1}{2}$ days. About 14 per cent were discharged within 48 hours of delivery in 1968. A possible distribution for 6 days is indicated in the table.

TABLE 1

Present situation

	1968	1969
Average number of beds available daily	22,800	23,300(†)
Per cent of beds used for antenatal care	27·5(*)	
Postnatal stay (stays)	6·6(*)	
Per cent occupancy	74	
Per cent of births in N.H.S. hospitals	79	

(*) Estimate H.I.P.E.

(†) Provisional.

TABLE 2

Number of births in N.H.S. hospitals according to assumptions about the proportion of births in hospitals

Per cent of births in N.H.S. hospitals		100%	90%	80%
Number of births (thousands) in N.H.S. hospitals	1969	850	765	680
	1970	866	779	693
	1971	878	790	702
	1981	927	834	742

Note: Provisional birth figures for 1969 indicate that the projection for this year is an overestimate (The projections used were the most recent available at the time of preparation).

TABLE 3

H.I.P.E. Maternity Cases—Duration of stay after delivery.
Percentage distribution of cases by number of days stay after delivery.

Length of stay (days)	1964		1965		1966		1967		1968		Possible distribution
All	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	1st half	2nd half	
0–2	9	10	11	12	12	13	14	14	14	15	18
3–4	7	8	8	10	10	11	11	12	12	13	15
5–6	10	10	12	12	13	13	13	13	14	15	19
7–8	30	30	29	29	29	29	28	28	28	27	24
9–10	33	32	30	28	27	25	25	24	23	22	17
11+	11	10	10	9	9	9	9	9	9	8	7
Mean stay	7·4		7·2		6·9		6·8		6·6		6·0

TABLE 4

To show the high correlation between pressure and throughput per available bed by region for 1968

Region	Pressure(*)	Throughput(†)	Ranking	
			Pressure	Throughput
East Anglia	45·5	28·9	1	8
Sheffield	43·9	31·6	2	3
Birmingham	42·4	31·9	3	1
Wessex	40·2	30·0	4	4
Oxford	39·3	31·7	5	2
Manchester	36·5	29·5	6	7
Leeds	36·5	29·2	7	6
Liverpool	35·6	29·7	8	5
Metropolitan	33·5	26·6	9	11
South Western	32·9	27·7	10	10
Newcastle	32·8	26·2	11	12
Wales	31·5	27·8	12	9

(*) All births per available bed.

(†) Hospital births per available bed.

TABLE 5

Estimates of maternity bed requirements (average number available daily) based on various assumptions

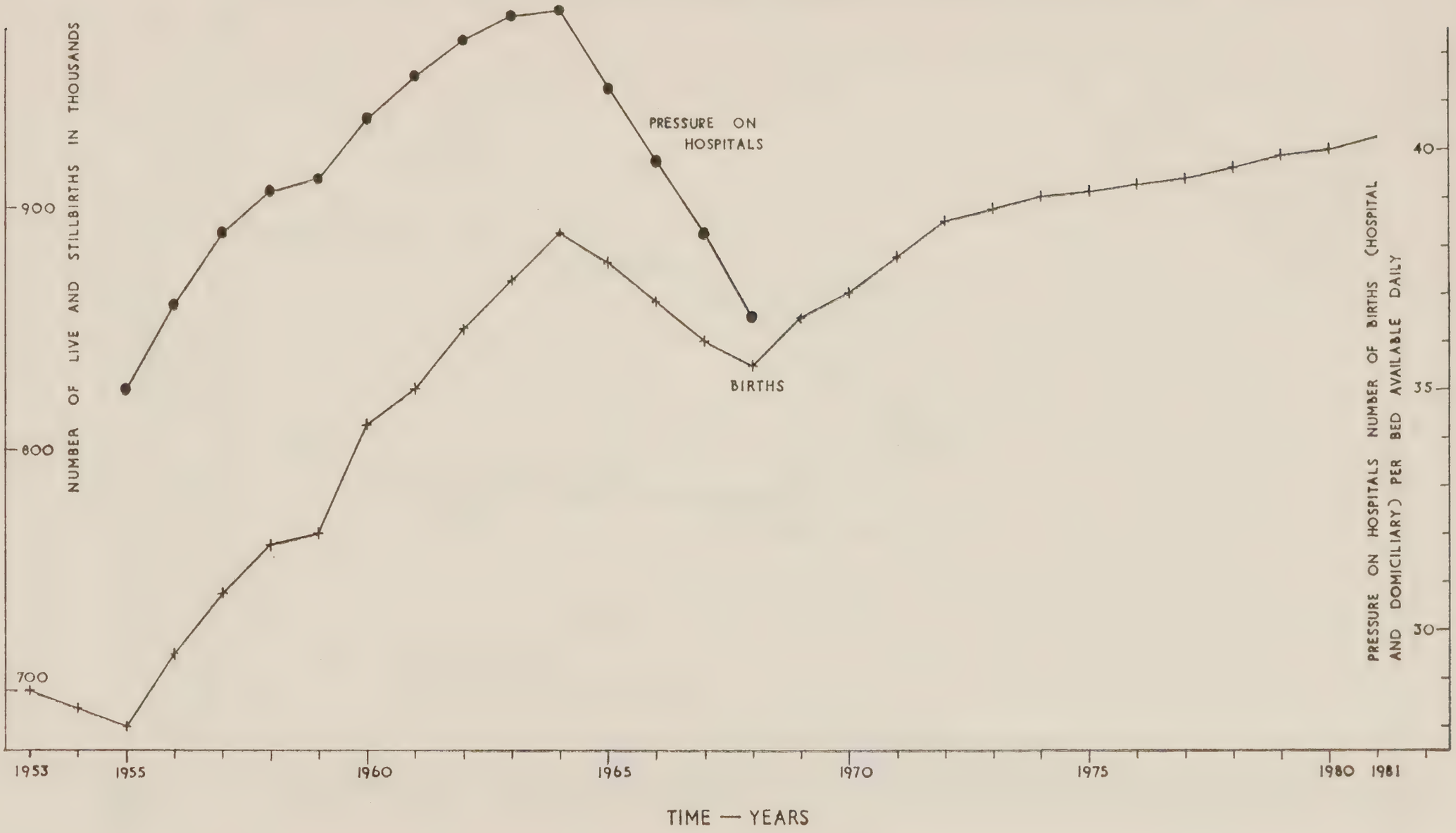
Postnatal stay		7 days											
Per cent beds used for antenatal care		25%						30%					
Present occupancy		75%			85%			75%			85%		
Per cent N.H.S. hospital confinement		80%	90%	100%	80%	90%	100%	80%	90%	100%	80%	90%	100%
	Year												
Beds (thousands)	1969	23·2	26·1	29·0	20·4	23·0	25·6	24·8	27·9	31·0	21·9	24·6	27·4
	1970	23·6	26·6	29·5	20·8	23·4	26·0	25·3	28·5	31·6	22·3	25·1	27·9
	1971	24·0	27·0	29·9	21·1	23·8	26·4	25·6	28·9	32·1	22·6	25·5	28·3
	1981	25·3	28·5	31·6	22·3	25·1	27·9	27·1	30·5	33·9	23·9	26·9	29·9

Postnatal stay		6 days											
Per cent beds used for antenatal care		25%						30%					
Per cent occupancy		75%			85%			75%			85%		
Per cent N.H.S. hospital confinement		80%	90%	100%	80%	90%	100%	80%	90%	100%	80%	90%	100%
	Year												
Beds (thousands)	1969	19·9	22·3	24·8	17·5	19·7	21·9	21·3	23·9	26·6	18·8	21·1	23·5
	1970	20·2	22·8	25·3	17·9	20·1	22·3	21·7	24·4	27·1	19·1	21·5	23·9
	1971	20·5	23·1	25·7	18·1	20·4	22·6	22·0	24·8	27·5	19·4	21·8	24·3
	1981	21·7	24·4	27·1	19·1	21·5	23·9	23·2	26·1	29·0	20·5	23·1	25·6

Post natal stay		5 days											
Per cent bed used for antenatal care		25%						30%					
Per cent occupancy		75%			85%			75%			85%		
Per cent N.H.S. hospital confinement		80%	90%	100%	80%	90%	100%	80%	90%	100%	80%	90%	100%
	Year												
Beds (thousands)	1969	16·6	18·6	20·7	14·6	16·4	18·3	17·7	20·0	22·2	15·7	17·6	19·6
	1970	16·9	19·0	21·1	14·9	16·7	18·6	18·1	20·3	22·6	15·9	17·9	19·9
	1971	17·1	19·3	21·4	15·1	17·0	18·9	18·3	20·6	22·9	16·2	18·2	20·2
	1981	18·1	20·3	22·6	15·9	17·9	19·9	19·4	21·8	24·2	17·1	19·2	21·4

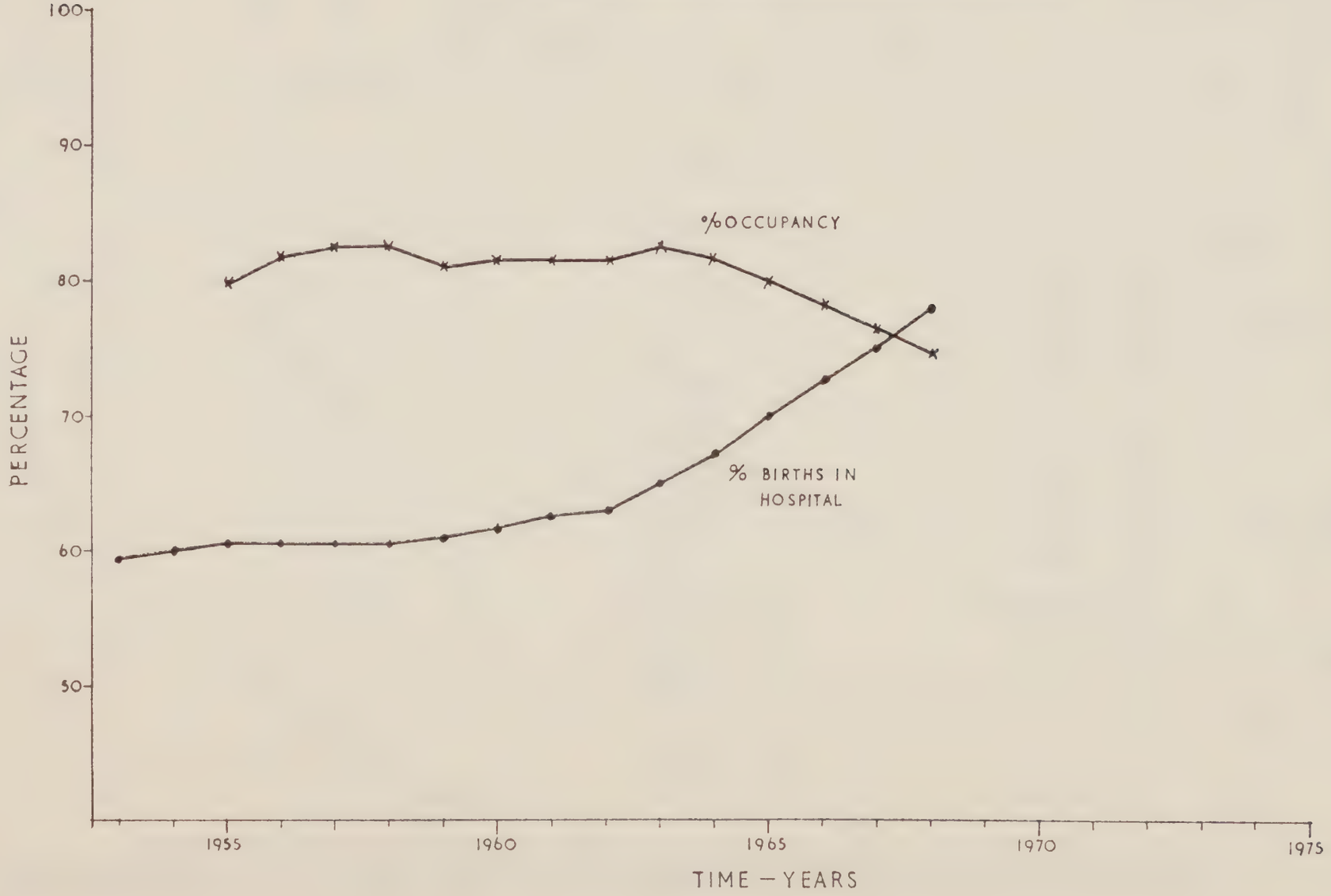
I

THE NUMBER OF LIVE AND STILLBIRTHS IN 1953 — 1968, WITH ESTIMATED UNTIL 1981; PRESSURE ON HOSPITALS (NUMBER OF LIVE AND STILLBIRTHS PER BED AVAILABLE DAILY) IN ENGLAND AND WALES.

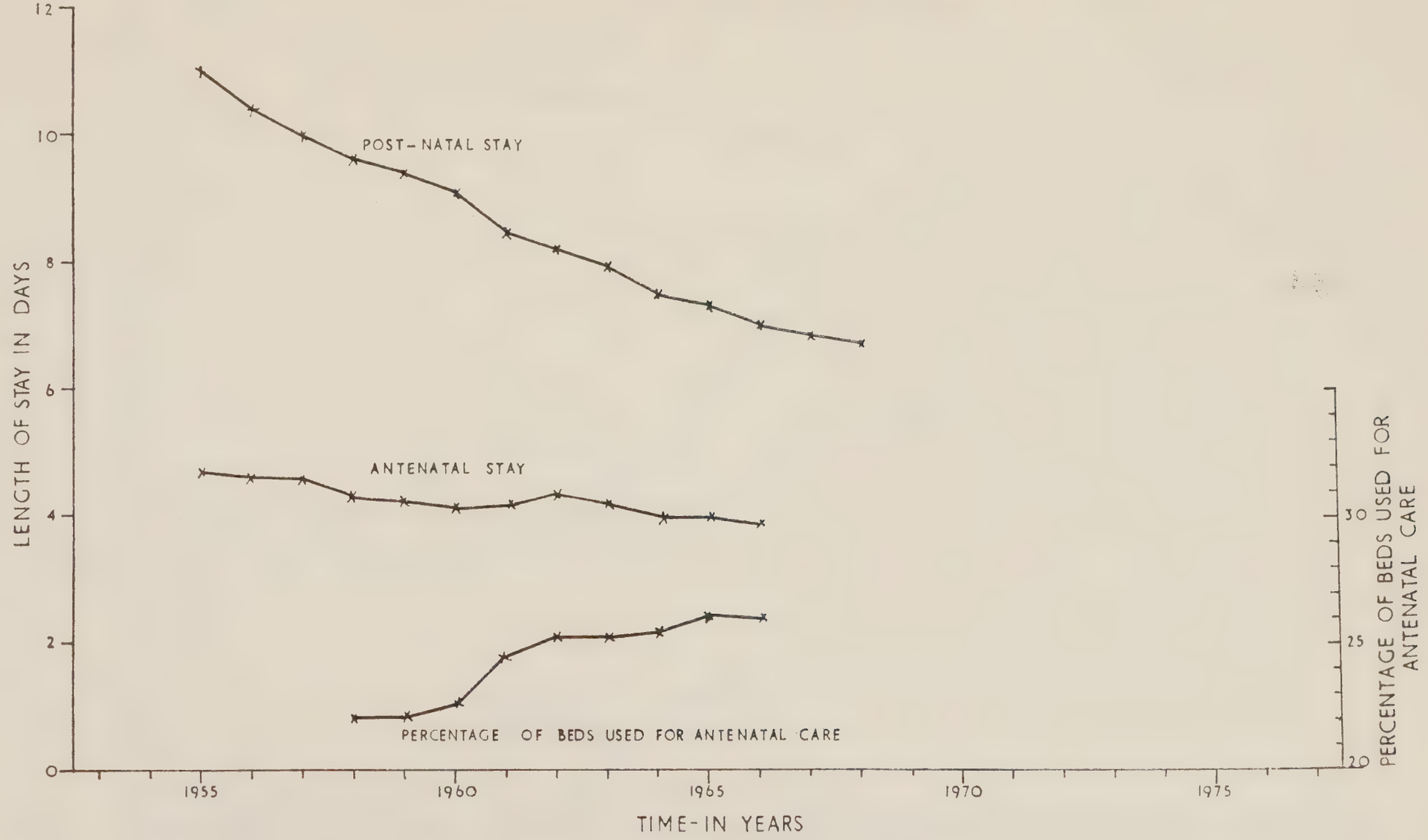


II

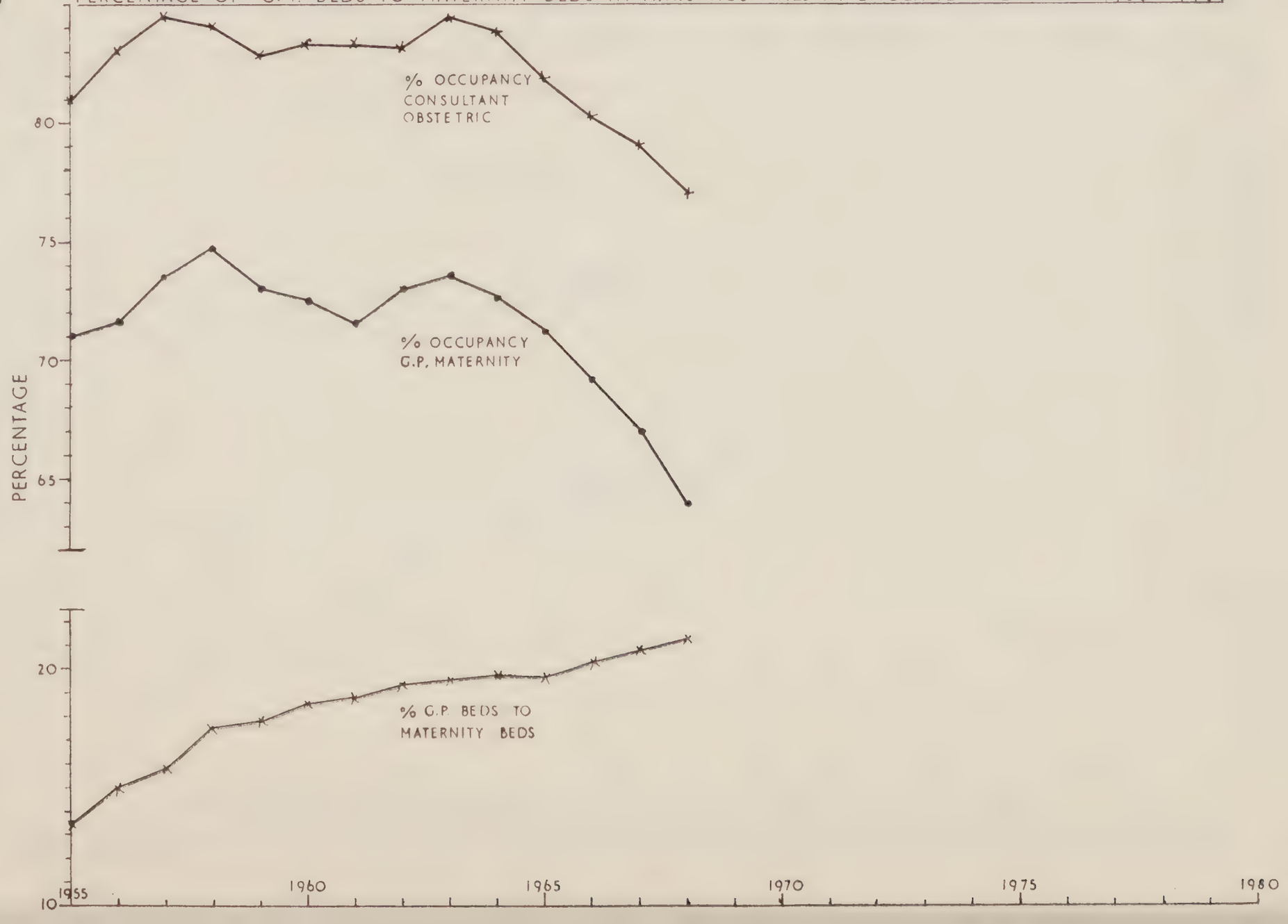
THE PERCENTAGE OF BIRTHS IN N.H.S. HOSPITALS, AND THE PERCENTAGE OF AVAILABLE BEDS OCCUPIED FOR 1953 – 1968 IN ENGLAND AND WALES



III THE MEAN LENGTH OF STAY PER SPELL FOR ANTENATAL AND POSTNATAL CARE, AND THE PERCENTAGE OF BEDS USED FOR ANTENATAL CARE IN N.H.S. HOSPITALS IN ENGLAND AND WALES 1955-1968.

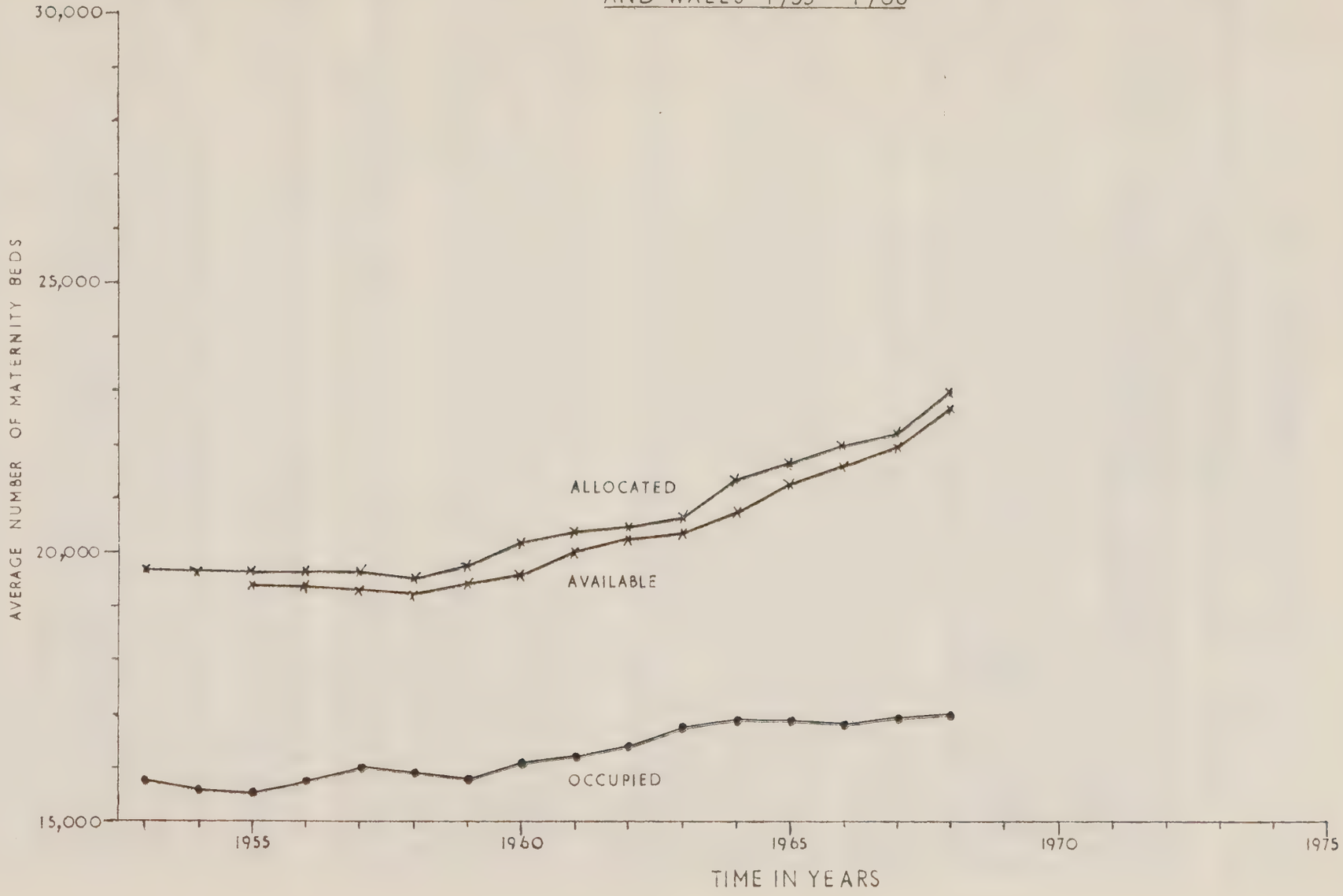


IV THE PERCENTAGE OF AVAILABLE BEDS OCCUPIED IN CONSULTANT OBSTETRIC AND G.P. MATERNITY UNITS AND THE PERCENTAGE OF G. P. BEDS TO MATERNITY BEDS IN N.H.S. HOSPITALS IN ENGLAND AND WALES 1955 - 1968



V

THE AVERAGE NUMBER OF MATERNITY BEDS ALLOCATED AVAILABLE AND OCCUPIED DAILY IN ENGLAND AND WALES 1953 – 1968



APPENDIX J

FACTORS AFFECTING THE PROVISION OF DELIVERY BEDS

1. To estimate the number of delivery beds needed, births are divided into three broad categories, namely, inductions, non-inductions and caesarian sections, and separate estimates made for the first two groups; the third is regarded as placing no burden on the delivery suite.

2. The Hospital In-patient Enquiry (1958 to 1966) shows that between 4 and 5 per cent of hospital deliveries are by caesarian section, and that the proportion of induced deliveries had increased steadily by about 1 per cent per annum to nearly 18 per cent in 1966. Table 1 shows the number of births in each group for birth rates ranging from 15 to 22 per 1,000 in a population of 200,000, with 100 per cent hospital confinement assuming that 20 per cent are induced, 5 per cent are by caesarian section and the remaining 75 per cent non-induced.

3. To estimate the number of delivery beds required for non-induced cases, two measures are required, namely, the average arrival rate of patients to the suite and the average time spent there. The technique is based on queueing theory and so takes into account the fact that in practice patients arrive at random and spend varying periods in the delivery suite. This method was first used by Thompson(†) etc. in the U.S.A., and also applied by the Department on a limited scale. In those papers the actual findings confirmed the theoretical results, but in the present study various models are presented only.

4. The procedure demonstrates for what proportion of the time the hospital can expect to treat simultaneously 0, 1, 2 etc. patients and can be applied to a combined suite, where the patient is allocated to one bed throughout the delivery or one in which separate 1st and 2nd stage rooms are provided and the patient is transferred. The present exercise is limited to a large unit with about 100 maternity beds, but can readily be extended to any unit.

5. The average arrival rate is derived from the number of births accommodated in the unit, which in turn is dependent on the policy concerning various factors.

Table 1 shows the average hourly arrival rate for the peak month (March) when statistics show 10 per cent more births occur than the average for the year, in total and in hospital.

6. The average stay in the suite depends basically on the duration of labour, but allowance must also be made at the first stage for false labour for some cases, and in all cases at the second stage for a period after delivery, when the patient receives intensive care and observation before transfer to the lying-in beds, and also for a short interval for room preparation between patients. In addition, patients delivered at night may not be transferred to the ward until morning, to avoid disturbing other patients and if porters are not available.

7. Table 2 shows the mean duration of the first and second stages of labour for primiparae, multiparae and all types of patients, based on the first Perinatal Mortality Survey of 1958, the small standard errors indicating the accuracy of the results. The longer duration of labour for primiparae is demonstrated and about 37 per cent of mothers in the survey were included in this group; by 1967, 42 per cent of hospital births were to primiparae, but this difference would not affect this exercise significantly. Also the 1958

survey was based on both hospital and domiciliary confinements and currently nearly 80 per cent of all births are in hospital compared to just over 60 per cent in the survey. More advanced techniques now used in hospital (and not possible at home) may have tended to reduce the duration of labour.

8. To allow a reasonable margin for these factors, average total stays of 16 or 18 hours were chosen, for the present calculations with average stays in the second stage of two or four hours, and Table 3 shows for an average arrival rate of 0·3 cases per hour, the corresponding distributions and hence the bed needs of the unit.

9. The combined suite is rarely unused, and requires 13 beds, if cases stay on average for 16 hours (or 14 beds, for 18 hours) to cope with the peak demand, but full use of the suite is rare, as shown by the low percentages corresponding to 10 or more patients. Alternatively, if separate rooms are used for the two stages, 12 beds are needed in the first stage, for a stay of 14 hours, and four or six beds in the second stage for stays of two or four hours. The second stage beds remain occupied for at least one-third of the time. Although the combined suite requires fewer beds than the other type, each bed must be as elaborately equipped as in the second stage suite, and so the slight saving in numbers may not represent a true economy.

10. Table 4 provides further estimates of delivery bed needs for various average stays, and arrival rates, corresponding to 3,000 to 4,400 births in the population of 200,000 and in each example the maximum bed need is given, corresponding to the final value in the percentage distribution, thus accommodating the peak demand for beds. 4,400 births annually require 18 combined suite beds, with an average stay of 18 hours, or 15 first stage beds, and seven second stage beds, with average stays of 14 and four hours respectively.

11. Induced deliveries can be planned to some extent but it is usual to arrange such cases in batches, rather than in a continuous flow, as delivery beds become available. The interval between the commencement of induction and onset of labour may vary between one and 24 hours, with an average of about 10–12 hours. Table 5 presents estimates of induced delivery bed needs, assuming one group of patients consisting of the same number every two or every three days, and annual numbers of cases varying between 600 and 880, corresponding to birth rates of 15 to 22 per thousand. As for non-induced cases, the maximum provision is provided in each example. For a birth rate of 22 per thousand, 8 beds are needed for a group every three days, and 5 for a group every two days. When a case experiences a short period of induction and labour, a bed in this area would be available to cope with any surplus from the main sector, for example, a case in false labour.

12. Examples of overall delivery bed needs induced and non-induced are shown in Table 6 for average stays of 16 or 18 hours (for non-induced cases) by type of suite, and the full range of birth rates considered. The maximum requirement, for 4,400 births and average stay of 18 hours, would be 26 combined suite beds, or 30 beds in a suite with separate provision at the first and second stages.

13. For each estimate, the maximum number of delivery beds has been allowed, as no alternative provision is suitable and inadequate arrangements in this highly specialised area could limit further extension of the hospital maternity service.

(†) J. B. Thompson and others.
The application of Queueing Theory to the usage pattern of a delivery suite. Yale Studies of Hospital Function and Design 1. 1960.

TABLE 1

Assumed number of births for a population of 200,000 served by a single maternity unit, by type of delivery, with estimated peak arrival rate per hour

Birth rate per 1,000	Annual number of births (100%)	Type of delivery			Average arrival rate per hour in peak month, for non-induced cases
		Induced (20%)	Caesarian (5%)	Non-induced (75%)	
15	3,000	600	150	2,250	0·28
16	3,200	640	160	2,400	0·30
17	3,400	680	170	2,550	0·32
18	3,600	720	180	2,700	0·34
19	3,800	760	190	2,850	0·36
20	4,000	800	200	3,000	0·38
21	4,200	840	210	3,150	0·40
22	4,400	880	220	3,300	0·41

TABLE 2

1958 Perinatal Survey: Duration of labour by stage and parity

		All		Primiparae		Multiparae	
1st stage	Mean (hours)	12·0		16·5		9·4	
	Standard error		0·08		0·17		0·08
2nd stage	Mean (hours)	0·70		1·09		0·47	
	Standard error		0·005		0·01		0·005
Number in 1958 Survey		16,400		6,100		10,300	

TABLE 3

Percentage distribution of time that patients are expected to be in labour suites, based on various assumptions

	2nd stage		Combined suite or 1st stage		
Average stay in stage (hours)	2	4	14	16	18
Average arrival rate (hourly)	0·3	0·3	0·3	0·3	0·3
Number of patients n	Percentage of time "n" patients are expected to be in suite simultaneously				
0	54·9	30·1	1·5	0·8	0·4
1	32·9	36·1	6·3	4·0	2·4
2	9·9	21·7	13·2	9·5	6·6
3	2·0	8·7	18·5	15·2	11·8
4	0·3	2·6	19·4	18·2	16·0
5	0	0·6	16·3	17·5	17·3
	100·0	0·1	11·4	14·0	15·6
6		0	6·9	9·6	12·0
7					
		99·9	3·6	5·8	8·1
8			1·7	3·1	4·8
9			0·7	1·5	2·6
10			0·3	0·6	1·3
11			0·1	0·2	0·6
12			0	0·1	0·2
13			99·9	0	0·1
14				100·0	0
15					99·8

TABLE 4

Delievery bed needs, excluding induction, at maximum level, by type of suite and annual number of births

Average stay in stage (hours)	2nd stage 2	4	Combined suite or 1st stage 14	16	18
Number of non-induced births annually	Number of delivery beds required				
2,250	4	6	12	13	14
2,400	4	6	12	13	14
2,550	4	6	13	14	15
2,700	5	6	13	14	15
2,850	5	7	14	15	16
3,000	5	7	14	15	17
3,150	5	7	14	16	17
3,300	5	7	15	16	18

TABLE 5

Induced delivery bed needs, assuming one group every 2 or 3 days

Number of births induced annually	Number of induced delivery beds required for	
	1 group every 3 days	1 group every 2 days
600	5	4
640	6	4
680	6	4
720	6	4
760	7	5
800	7	5
840	7	5
880	8	5

TABLE 6

Examples of total delivery bed needs by type of suite, assuming average stay of 16 or 18 hours for non-induced cases, and an induced group every 3 days

Annual number of births	Number of delivery beds needed for			
	Combined Suite (Stay = 16hours)	Separate 1st and 2nd stages (1st stage stay = 14 hours 2nd stage stay = 2 hours)	Combined Suite (Stay = 18 hours)	Separate 1st and 2nd stages (1st stage stay = 14 hours 2nd stage stay = 4 hour)
3,000	18	21	19	23
3,200	19	22	20	24
3,400	20	23	21	25
3,600	20	24	21	25
3,800	22	26	23	28
4,000	22	26	24	28
4,200	23	26	24	28
4,400	24	28	26	30

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